No. 2
5-42
17-39
X32873

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED FEB 16 1943

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 257 6539

Registration District No. 154 Primary Registration District No. 5575 Registrar's No. 13

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:
(a) County Jackson
(b) City or town Kansas City
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 8008 Lydia
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution ..... (Specify whether
In this community 14 years
years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo. (b) County Jackson
(c) City or town Kansas City
(If outside city or town limits, write "RURAL")
(d) Street No. 8008 Lydia
(If rural, give location)
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country 0

3. (a) PRINT FULL NAME John Henry Houk
3. (b) If veteran, name war no
3. (c) Social Security No. no
4. Sex Male
5. Color or race W
6. (a) Single, widowed, married, divorced 2 Wid
6. (b) Name of husband or wife Cora Houk
6. (c) Age of husband or wife if alive ..... years
7. Birth date of deceased ..... (Month) (Day) (Year)

8. AGE: Years 82 Months Days If less than one day ..... hr. ..... min.

9. Birthplace ..... (City, town, or county) mo 0 (State or foreign country)
10. Usual occupation Labor
11. Industry or business
FATHER
12. Name William Houk
13. Birthplace ..... (City, town, or county) mo 0 (State or foreign country)
MOTHER
14. Maiden name Martha William
15. Birthplace ..... (City, town, or county) no 0 (State or foreign country)
16. (a) Informant Mrs. Rose Shanks
(b) Address 8008 Lydia
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-1-43 (Month) (Day) (Year)
(c) Place: burial or cremation Greenlawn Cem
18. (a) Signature of funeral director Mrs. C. L. Forster
(b) Address K. C.
19. (a) 2/3/43 (Date received local registrar) Sub R.O. Lindsey Stone Inc (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 25
year ..... hour 8 minute 4 A.M.
21. I hereby certify that I attended the deceased from 1-23-43
1- , 19..., to 1-25 , 1943
that I last saw him alive on 1-23 , 1943
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Coronary Accident	
Due to Arterio Sclerosis Chronic Nephritis	
Due to	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations	
Of autopsy	

131 P

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify)
(b) Date of occurrence
(c) Where did injury occur? ..... (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?
..... (Specify type of place)
While at work? ..... (e) Means of injury
23. Signature Geo. Jones (M. D. or other)
Address 80 + Pasco Date signed 1/25/43

Dr. Annie E. Hedges

(Reverse Side)

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

....., Registered Apprentice No.....,

working under my personal supervision.

Signed Denzil C. Browning

Licensed Embalmer No. 2724

P. O. Address K. C. Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

S. No. 2B
M—8-21-41
I X29288

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 6539

Registration District No. ..... Primary Registration District No. 5575 Registrar's No. .....

1. PLACE OF DEATH:

(a) County Jackson

(b) City or town Kansas City
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution ..... (Specify whether
In this community ..... years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Jackson

(c) City or town Kansas City
(If outside city or town limits, write "RURAL")

(d) Street No. 8008 Lydia
(If rural, give location)

(e) Citizen of foreign country? ..... (Yes or No)

If yes, name country .....

3. (a) PRINT FULL NAME John H Houck

3. (b) If veteran, name war — 3. (c) Social Security No. —

4. Sex ..... 5. Color or race ..... 6. (a) Single, widowed, married, divorced .....

6. (b) Name of husband or wife ..... 6. (c) Age of husband or wife if alive ..... years

7. Birth date of deceased Family doesn't know definite (Month) (Day) (Year)

8. AGE: Years 82 Months Days If less than one day ..... hr. ..... min.

9. Birthplace ..... (City, town, or county) ..... (State or foreign country)

10. Usual occupation .....

11. Industry or business .....

MOTHER FATHER
12. Name .....
13. Birthplace ..... (City, town, or county) ..... (State or foreign country)
14. Maiden name .....
15. Birthplace ..... (City, town, or county) ..... (State or foreign country)

16. (a) Informant .....
(b) Address .....

17. (a) ..... (Burial, cremation, or removal) (b) Date thereof ..... (Month) (Day) (Year)
(c) Place: burial or cremation .....

18. (a) Signature of funeral director .....
(b) Address .....

19. (a) ..... (Date received local registrar) (b) ..... (Registrar's signature)

MEDICAL CERTIFICATION

20. **DATE OF DEATH:** Month Jan day 25
year 1943 hour ..... minute ..... M.

21. I hereby certify that I attended the deceased from ..... 19..., to ..... 19...;
that I last saw h..... alive on ..... 19...;
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death	
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations	
Of autopsy	

PHYSICIAN

Underline the cause to which death should be charged statistically.

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(a) Accident, suicide, or homicide (specify) .....
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(c) Where did injury occur? ..... (City or town) (County) (State)
(b) Did injury occur in or about home, on farm, in industrial place, in public place? ..... (Specify type of place)
While at work? ..... (c) Means of injury .....

23. Signature Fred H Jones (M. D. or other)
Address 804 + Paseo Date signed 4/5/43

SUPPLEMENTARY