

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No.

23746

FILED JUL 24 1944 49

Primary Registration District No. 1002

Registrar's No. 2877

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:
Research Hospital,
(If not in hospital or institution, write street number or location) 0

(d) Length of stay: In hospital or institution 3 weeks (Specify whether)

In this community 50 years, (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson, **48**

(c) City or town Kansas City, **38**
(If outside city or town limits, write "RURAL")

(d) Street No. 435 East 55th Street,
(If rural, give location)

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

If yes, name country x **0**

3. (a) PRINT FULL NAME William B. Houston,

3. (b) If veteran, name war no.

3. (c) Social Security No. no.

4. Sex Male **0** 5. Color or race White

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Gertrude Houston

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

7. Birth date of deceased October 2 1875
(Month) (Day) (Year)

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

68 9 8 hr. min.

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

10. Usual occupation Bond Salesman

11. Industry or business Stocks and Bonds

12. Name Granklin Houston

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

14. Maiden name Harriett Brown

15. Birthplace Missouri, **0**
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Gertrude Houston,

(b) Address 435 E. 55th St., Kansas City, Mo.

17. (a) Removal (Burial, cremation, or removal) (b) Date thereof 7-12-44
(Month) (Day) (Year)

(c) Place: burial or cremation Springfield, Illinois,

18. (a) Signature of funeral director Stine & McClure,

(b) Address 3235 Gillham Plaza, K. C., Mo.

19. (a) 7-11-44 (Date received local registrar) (b) N. E. Brown (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 10th
year 1944 hour 8:45 minute P. M.

21. I hereby certify that I attended the deceased from 6-4-44
7-10-44 to 7-10-44 1944;
that I last saw h. E. alive on 7-16- 1944
and that death occurred on the date and hour stated above.

Immediate cause of death Hypertensive Preynony
Bi Color. Bronchial. Duration

Due to Hypertension, cerebral failure

Due to Orchid meningitis

Other conditions 83a!
(Include pregnancy within 3 months of death)

Major findings: Of operations 83a!

Of autopsy 83a!

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? _____

While at work? _____ (Specify type of place)

(e) Means of injury 83a!

23. Signature N. E. Brown (M. D. or other)

Address 2202 E 72nd Date signed 7/11/44

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

MOTHER FATHER

PHYSICIAN

Underline the cause to which death should be charged statistically.

Prof. Black

Dr. Don Black

NOT IN USE

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

[Signature]

Licensed Embalmer No. *14157*

P. O. Address *14157*

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.