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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

36222

FILED DEC 12 1945 STANDARD CERTIFICATE OF DEATH

State File No. _____

Registration District No. 149

Primary Registration District No. 1002

Registrar's No. 4891

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: 3720 Main Street /
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution XX
4 weeks (Specify whether
 In this community _____
 years, months or days)

2. USUAL RESIDENCE OF DECEASED:
 (a) State Missouri (b) County Buchanan
 (c) City or town St. Joseph
 (If outside city or town limits, write "RURAL")
 (d) Street No. _____ (If rural, give location)
 (e) Citizen of foreign country? _____ (Yes or No)
 If yes, name country _____

3. (a) PRINT FULL NAME JOHN W. HOUSTON
 (b) If veteran, name war No
 (c) Social Security No. None

MEDICAL CERTIFICATION
 20. **DATE OF DEATH:** Month Nov. day 28th
 year 1945 hour 6: minute 15 AM.
 21. I hereby certify that I attended the deceased from Nov 10
1945 to Nov 27 1945
 that I last saw him alive on Nov 27 1945
 and that death occurred on the date and hour stated above.

4. Sex Ma 5. Color or race Wh
 6. (b) Name of husband or wife Mary A. Houston
 6. (c) Age of husband or wife if alive XX years
 7. Birth date of deceased August 2 1861
 (Month) (Day) (Year)

Immediate cause of death Chronic Myocarditis & Nephritis
 Duration _____
 Due to _____
 Due to _____

8. AGE: Years 84 Months 3 Days 26
 If less than one day _____ hr. _____ min.

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

10. Usual occupation Bakery Operator
Own Business

11. Industry or business _____

12. Name Thomas Houston

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

14. Maiden name Susan Townsend

15. Birthplace Kv /
 (City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Frances Bright
 (b) Address 3720 Main St.

17. (c) Place: burial or cremation Burial
 (Burial, cremation, or removal) (b) Date thereof 11-28-45
 (Month) (Day) (Year)
Gulfport, Mo.

18. (a) Signature of funeral director J.W. Wagner
 (b) Address Kansas City, Mo.

19. (a) 11-28-45 (Date received local registrar)
 (b) Theraldine Holmes (Registrar's signature)

Other conditions (Include pregnancy within 3 months of death) _____
 Major findings: _____
 Of operations _____
 Of autopsy _____
ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED
 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?
 While at work? _____ (Specify type of place) _____
 Means of injury _____
 Signature Wm. W. Childers (M.D. or other) W.C.
 Address 616 Chambers Bldg Date signed 11-28-45

(Licensed Embalmer's Statement on Reverse Side)

K.C., Mo

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

MOTHER FATHER

11-8759
KANSAS
EMBALMER
REGISTERED

PLATE
C. BYCK

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 Cecil R. Matthes

Licensed Embalmer No. 3807

P. O. Address Kansas City, 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.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 1111
Registrar's No. 4891

Registration District No. 149

Primary Registration District No. 1002

1. PLACE OF DEATH:
(a) County Jackson
(b) City or town Kennett 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 _____ (Specify whether _____)
years, months or days

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

3. (a) PRINT FULL NAME John W. Houston
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex m 5. Color or race w
6. (a) Single, widowed, married, divorced wid
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased: aug 2 1916
(Month) (Day) (Year)
8. AGE: Years 84 Months 3 Days 6 (If less than one day _____ min.)

9. Birthplace Iowa
(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) _____ (b) Date thereof _____
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation _____

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

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month _____ year 19 hour _____ minute _____ M.
21. I hereby certify that I attended the deceased from _____ to _____, 19____; that I last saw him _____ alive on _____, 19____; and that death occurred on the date and hour stated above.

Immediate cause of death: Chronic Myocarditis
Chronic Nephritis
Due to _____
Due to _____
Other conditions: _____ (Include pregnancy within 3 months of death)

Major findings: _____
Of operations _____
Of autopsy _____

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)
(a) Means of injury _____
23. Signature W. J. Childers (M. D. or other) _____
Address 25 East 12th St Date signed 12-15-45
Kennett City 6-100

SUPPLEMENTARY

Duration

unknown

PHYSICIAN

Underline the cause to which death should be charged statistically.

36222