

FILED MAY 17 1946

Registration District No. 46

Primary Registration District No. 4065

1. PLACE OF DEATH:

(a) County Caldwell
(b) City or town Polo
(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 Caldwell
(c) City or town Polo
(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 Wm. Robert Houston

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

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

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

7. Birth date of deceased March 11 - 1965
(Month) (Day) (Year)

8. AGE: Years 81 Months 1 Days 19 If less than one day _____ hr. _____ min.

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

10. Usual occupation Retired

11. Industry or business _____

MOTHER FATHER { 12. Name Wm Houston
13. Birthplace Tenn
(City, town, or county) (State or foreign country)
14. Maiden name Nancy Baker
15. Birthplace Tenn
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs Fannie Hopkins

(b) Address Polo mo

17. (a) Burial (b) Date thereof _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Polo mo

18. (a) Signature of funeral director Abraham Cowley

(b) Address Polo mo

19. (a) May 3/46 (b) Gladys Jones
(Date registered for burial) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 30
year 1946 hour 1 minute a. M.

21. I hereby certify that I attended the deceased from April 30 1946, to April 30 1946
that I last saw him alive on April 29 1946
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Hemorrhage

Due to _____
Due to _____
Other conditions (Include pregnancy within 3 months of death) _____

Major findings: Of operations (Signature)
Of autopsy _____

Duration _____
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? _____

While at work? _____ (Specify type of place) (e) Means of injury 1

23. Signature Ockilbourm (M. D. or other) _____
Address Cowdill, MO Date signed 7/30/46

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

11276

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.....

Licensed Embalmer No.....

P. O. Address.....

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.