

FILED DEC 24 1946  
Registration District No. 205

Primary Registration District No. 5740

Registrar's No. 7

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

1. PLACE OF DEATH:

(a) County Macon

(b) City or town LINGO Twp. Rural  
(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 years, months or days)

In this community 52 Years

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3. (a) PRINT FULL NAME James F. Houghton

3. (b) If veteran, name war No

3. (c) Social Security No. No

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4. Sex Male

5. Color or race White

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

6. (b) Name of husband or wife \_\_\_\_\_

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

7. Birth date of deceased March 9, 1894  
(Month) (Day) (Year)

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8. AGE:	Years	Months	Days	If less than one day
	<u>52</u>	<u>8</u>	<u>15</u>	hr. _____ min. _____

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

10. Usual occupation Farmer

11. Industry or business \_\_\_\_\_

12. Name Walter L. Houghton

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

14. Maiden name Mary A. Simmons

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

16. (a) Informant Walter L. Houghton

(b) Address New Cambria, Mo.

17. (a) Burial (Burial, cremation, or removal)

(b) Date thereof 11/26/46  
(Month) (Day) (Year)

(c) Place: burial or cremation New Cambria, Mo.

18. (a) Signature of funeral director James McLaughlin

(b) Address Marceline Mo.

19. (a) Dec. 14, 1946 (Date received local registrar)

(b) Alman M. Gillilan (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Macon

(c) City or town Rural  
(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 \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 11 day 24  
year 1946 hour 9 minute 30 M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, 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 \_\_\_\_\_

Anemic Emaciation

Due to \_\_\_\_\_

Due to (Coronary Juy Disease)

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

Major findings: Chemical analysis of

Of operations YISORA by STATE PATHOL

Of autopsy (Anemic Emaciation)

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 11-24-46

(c) Where did injury occur? New Cambria Mo  
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?  
on farm

While at work? Deliver (Specify type of place) (e) Means of injury ✓

23. Signature H. S. Edwards (M.D. or other)

Address Bevier Mo. Date signed 12/9/46

RECEIVED  
District Health Officer No. 10  
District File Number 12-46-2365  
Date Filed DEC-20-1946

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 Blanche M Laughlin  
Licensed Embalmer No. 19091  
P. O. Address Marceline 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.