

No. 2
-1/47
5-17-39

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 28204

FEDERAL SECURITY AGENCY
National Office of Vital Statistics
FILED SEP 15 1947
Registration District No. 1/1947

Primary Registration District No. 5627

Registrar's No.

1. PLACE OF DEATH:
(a) County Laclede
(b) City or town 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 _____)
In this community _____ years, months or days

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Laclede 53
(c) City or town Competition (Rural) 0
(If outside city or town limits, write "RURAL") 0
(d) Street No. _____ (If rural, give location) 0
(e) Citizen of foreign country? no (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Betty Joyce Hough
3. (b) If veteran, _____ 3. (c) Social Security No. _____
name war _____

4. Sex F / 5. Color or race W 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 June 24 1945
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
2 2 5 hr. _____ min.

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

10. Usual occupation _____

11. Industry or business _____

12. Name Lewis A Hough
13. Birthplace Laclede Co. Mo. ()
(City, town, or county) (State or foreign country)

14. Maiden name Elsie M. Dowell
15. Birthplace Laclede Co. Mo. ()
(City, town, or county) (State or foreign country)

16. (a) Informant Lewis A Hough
(b) Address Competition Mo.

17. (a) Burial (b) Date thereof 8-31-47
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Porter Chapel

18. (a) Signature of funeral director W.E. Holzman
(b) Address Lebanon Mo.

19. (a) Sept 6, 1947 (b) Dr. Jankubey
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug. day 29
year 1947 hour 8 minute 30 P.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 Basal skull fracture.

Due to Trampled by a horse

Due to _____

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

PHYSICIAN
Major findings:
Of operations 180
Of autopsy 19

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) Accident 53
(b) Date of occurrence 8/29/47

(c) Where did injury occur? Rural Laclede Mo.
(City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? Farm home near Competition Mo.
(Specify type of place)
While at work? no (e) Means of injury skull fracture

23. Signature D. Palmer (M.D. or other) 3
Address Lebanon Mo. Date signed 8/30/47

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

MOTHER FATHER

Received ----- 9/12/47 -----
Laclede County Health Unit
File No. 8-47-144 -----
Date Filed 9/13/47 -----

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 Dorsey M. Howe
Licensed Embalmer No. 4222
P. O. Address Lebanon 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.