. S. No. 2
OM—1/47
ev. 5-17-39

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

FEDERAL SECURITY AGENCY
National Office of Vital Statistics

FILED OCT 9 1947

Registration District No. 1

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 31696

Primary Registration District No. 5627

Registrar's No.

1. PLACE OF DEATH:
(a) County: Laclede
(b) City or town: Rural Franklin Twp. (If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Competition Mo. (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: always

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

3. (a) PRINT FULL NAME: Addie E. Hough
3. (b) If veteran, name war
3. (c) Social Security No.
4. Sex: F
5. Color or race: W
6. (a) Single, widowed, married, divorced: widowed
6. (b) Name of husband or wife: Noah Hough
6. (c) Age of husband or wife if alive ..... years
7. Birth date of deceased: May (Month) 29 (Day) 1860 (Year)

8. AGE: Years 87 Months 3 Days 9 If less than one day ..... hr. ..... min.

9. Birthplace: Laclede Co. (City, town, or county) Mo. (State or foreign country)
10. Usual occupation: House wife
11. Industry or business
MOTHER FATHER
12. Name: Robert Kinchelow
13. Birthplace: Louisville (City, town, or county) Ky (State or foreign country)
14. Maiden name: Mary E. Dyer
15. Birthplace: (City, town, or county) Tenn. (State or foreign country)
16. (a) Informant: G. W. Hough
(b) Address: Competition Mo.
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: 9-4-47 (Month) (Day) (Year)
(c) Place: burial or cremation: Hough Chapel
18. (a) Signature of funeral director: Palmer
(b) Address: Lebanon, Mo.
19. (a) Oct 4, 1947 (Date received local registrar) (b) Ora Frankberg (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 9 day 3 year 1947 hour 3 minute 40 P.M.
21. I hereby certify that I attended the deceased from Aug 27, 1947, to Aug 28, 1947, that I last saw her alive on Aug 28, 1947, and that death occurred on the date and hour stated above.

Immediate cause of death: Lobar pneumonia — Duration
Due to:
Due to:
Other conditions (Include pregnancy within 3 months of death):
Major findings:
Of operations: 8
Of autopsy: 10

PHYSICIAN
Underline the cause of 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? (Specify type of place)
While at work? (e) Means of injury
Signature: J. L. Hough (M. D. or other)
Address: Grove Spring Mo. Date signed

Jefferson City Printing Co.

(Licensed Embalmer's Statement on Reverse Side)

Received 10/7/47

Laclede County Health Unit

File No. 9-47-160

Date Filed 10/8/47

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 J. R. Palmer

Licensed Embalmer No. 2208

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.