

**THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH**

**40175**

State File No. ....

No. 300  
10-48

**FILED DEC 20 1954**

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 42 PRIMARY REG. DIST. NO. 1000 Registrar's No. 1293

|  |  |   |  |
|--|--|---|--|
| <b>1. PLACE OF DEATH</b><br>a. COUNTY <u>Buchanan</u>  |  | <b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: residence before admission).<br>a. STATE <u>Missouri</u><br>b. COUNTY <u>Nodaway</u> |  |
| b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Joseph</u> |  | c. CITY OR TOWN <u>Hopkins</u>  | d. Is residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> <u>YAH</u> |
| c. LENGTH OF STAY (in this place) <u>2 da's</u>  |  | e. STREET ADDRESS (If rural, give location) <u>R.F.D. 4 1/2 Mi. S.E. of Hopkins</u>   |  |
| d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Mo. Methodist Hospital</u>                          |  |   |  |

|  |                                      |  |   |  |   |
|--|--------------------------------------|--|---|--|---|
| <b>3. NAME OF DECEASED</b><br>(Type or Print) a. (First) <u>Dola</u> b. (Middle) <u>Grace</u> c. (Last) <u>Houston</u> |                                      |  | <b>4. DATE OF DEATH</b> (Month) (Day) (Year) <u>Dec. 9, 1954</u>              |  |   |
| <b>5. SEX</b> <u>Female</u>  | <b>6. COLOR OR RACE</b> <u>White</u> | <b>7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED</b> (Specify) <u>Married</u> | <b>8. DATE OF BIRTH</b> <u>Aug. 1, 1883</u>                                   | <b>9. AGE</b> (In years last birthday) <u>71</u> | <b>10. IF UNDER 1 YEAR</b> Days _____             |
| <b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Housewife</u>    |                                      | <b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>At Home</u>                      | <b>11. BIRTHPLACE</b> (City and State or Foreign Country) <u>Hopkins, Mo.</u> |  | <b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u> |

|   |  |  |  |  |  |
|---|--|--|--|--|--|
| <b>13a. FATHER'S NAME</b> <u>John McBeth</u>  |  | <b>13b. MOTHER'S MAIDEN NAME</b> <u>Ollie Worley</u> |  | <b>14. NAME OF HUSBAND OR WIFE</b> <u>Bruce Houston</u>  |  |
| <b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) |  | <b>16. SOCIAL SECURITY NO.</b> <u>None</u>           |  | <b>17. INFORMANT'S SIGNATURE OR NAME</b> <u>Mrs Ruth Long</u> <b>ADDRESS</b> <u>Kansas City, Mo.</u> |  |

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|---|--|--|--|
| <b>18. CAUSE OF DEATH.</b><br>Enter only one cause per line for (a), (b), and (c)<br><br>*This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death. | <b>I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*</b> (a) <u>Myocardial Infarction</u> |  | <b>INTERVAL BETWEEN ONSET AND DEATH</b><br><u>4 days</u><br><u>?</u><br><u>7 days</u>      |
|   | ANTECEDENT CAUSES<br><u>Coronary Arteriosclerosis</u>                                      |  |  |
|   | DUE TO (b) _____<br>DUE TO (c) _____   |  |  |
| <b>II. OTHER SIGNIFICANT CONDITIONS</b><br>Conditions contributing to the death but not related to the disease or condition causing death. <u>Pneumonia, Rt. Lower lobe.</u>  |  |  |  |
| <b>19a. DATE OF OPERATION</b>   | <b>19b. MAJOR FINDINGS OF OPERATION</b>  |  | <b>20. AUTOPSY?</b><br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |

|  |  |  |
|--|--|--|
| <b>21a. ACCIDENT SUICIDE HOMICIDE</b> (Specify)              | <b>21b. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)                  | <b>21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)</b> |
| <b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) _____ | <b>21e. INJURY OCCURRED</b><br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | <b>21f. HOW DID INJURY OCCUR?</b>                      |

22. I hereby certify that I attended the deceased from 12-7, 1954, to 12-9, 1954, that I last saw the deceased alive on 12-8, 1954, and that death occurred at 12:20am, from the causes and on the date stated above.

|  |  |  |
|--|--|--|
| <b>23a. SIGNATURE</b> <u>[Signature]</u> (Degree or title) <u>M.D.</u> | <b>23b. ADDRESS</b> <u>St. Joseph, Mo.</u> | <b>23c. DATE SIGNED</b> <u>12-10-54</u>                                  |
| <b>24a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Removal</u>        | <b>24b. DATE</b> <u>Dec. 9, 1954</u>       | <b>24c. NAME OF CEMETERY OR CREMATORY</b> <u>Hopkins Cemetery</u>        |
|  |  | <b>24d. LOCATION</b> (City, town, or county) (State) <u>Hopkins, Mo.</u> |

|   |   |  |
|---|---|--|
| <b>DATE REC'D BY LOCAL REG.</b> <u>Dec 13, 1954</u> | <b>REGISTRAR'S SIGNATURE</b> <u>[Signature]</u> | <b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <u>[Signature]</u> <b>ADDRESS</b> <u>St. Joseph, Mo.</u> |
|---|---|--|

(Licensed Embalmer's Statement on Reverse Side)

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

NOV 6 1964

4466 18-641

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 ....., Student Embalmer No. .... working under my personal supervision..

Student .....  
Signature of Student Embalmer

Signed *Robert H. Gable*

Licensed Embalmer No. **3308**

P. O. Address **St. Joseph,**

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.