

FILED MAR 15 1955

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **7056**

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **360** PRIMARY REG. DIST. NO. **6225** Registrar's No. **21**

1. PLACE OF DEATH a. COUNTY <b>Vernon</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Mo</b> b. COUNTY <b>Newton</b>	
b. CITY (If outside corporate limits, write RURAL and give town) <b>Wash. Township</b>	c. LENGTH OF STAY (In this place) <b>5m 15d.</b>	c. CITY OR TOWN <b>Neosho</b>	d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>State Hosp 3 Nevada Mo.</b>		e. STREET ADDRESS (If rural, give location) <b>209 N. Main 07321</b>	

3. NAME OF DECEASED (Type or Print) a. (First) <b>JOHN</b> b. (Middle) <b>-WILLIAM-</b> c. (Last) <b>HOUSDEN</b>	4. DATE OF DEATH (Month) (Day) (Year) <b>March 10, 1955</b>
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5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>widowed</b>	8. DATE OF BIRTH <b>Dec 15, 1871</b>	9. AGE (In years last birthday) <b>83</b>	IF UNDER 1 YEAR Months <b>2</b>	IF UNDER 24 HRS. Days <b>23</b> Hours <b>-</b> Mins. <b>-</b>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>f. farmer</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>none</b>	11. BIRTHPLACE (City and State or Foreign Country) <b>Lincoln Mo.</b>	12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
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13a. FATHER'S NAME <b>unknown</b>	13b. MOTHER'S MAIDEN NAME <b>unknown</b>	14. NAME OF HUSBAND OR WIFE <b>unknown</b>
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>	16. SOCIAL SECURITY NO. <b>none</b>	17. INFORMANT'S SIGNATURE OR NAME <b>Records State Hosp 3 Nevada Mo</b>	ADDRESS <b>Nevada Mo</b>
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Arteriosclerotic</b>		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <b>Heart Disease</b> DUE TO (c) <b>Senile Psychosis</b>		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <b>Fracture left hip 2-14-55</b>			

19a. DATE OF OPERATION <b>no</b>	19b. MAJOR FINDINGS OF OPERATION <b>none</b>	<b>E9027</b>	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify) <b>Fall, fracture left hip</b>	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>ward of hospital</b>	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <b>Nevada Vernon Mo.</b>
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <b>2-14-55 A.m.</b>	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	21f. HOW DID INJURY OCCUR? <b>Fall out of bed. 2-14-55.</b>
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22. I hereby certify that I attended the deceased from **Sept 23, 1954**, to **March 10, 1955**, that I last saw the deceased alive on **March 9, 1955**, and that death occurred at **2 A. M.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <b>Paul L. Barone, M.D.</b>	23b. ADDRESS <b>State Hosp 3 Nevada Mo</b>	23c. DATE SIGNED <b>Mar 10/55.</b>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removed</b>	24b. DATE <b>3-10-55</b>	24c. NAME OF CEMETERY OR CREMATORY <b>Seeling Cemetery</b>	24d. LOCATION (City, town, or county) (State) <b>Seeling, Missouri</b>
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DATE REC'D BY LOCAL REG. <b>3-12-1955</b>	REGISTRAR'S SIGNATURE <b>WMAE</b>	25. FUNERAL DIRECTOR'S SIGNATURE <b>Hervey S. Thompson</b>	ADDRESS <b>Funeral Home Neosho, Mo.</b>
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(Licensed Embalmer's Statement on Reverse Side)

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

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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 *Francis C. Marshall*

Licensed Embalmer No. 497

P. O. Address Nevada

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.