

FILED NOV 28 1956

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 38060

4880

BIRTH NO. _____ REG. DIST. NO. 149 PRIMARY REG. DIST. NO. 1002 Registrar's No. _____

1. PLACE OF DEATH a. COUNTY JACKSON		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE Arkansas b. COUNTY Jefferson	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN KANSAS CITY		c. LENGTH OF STAY (In this place) 2 Months	c. CITY OR TOWN Pine Bluff
d. FULL NAME OF HOSPITAL OR INSTITUTION 1618 Jackson Ave		d. Is residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or Print) a. (First) JEFF b. (Middle) ----- c. (Last) HOUSTON		4. DATE OF DEATH (Month) (Day) (Year) NOV 8th 1956	
5. SEX male	6. COLOR OR RACE Negro	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) widowed	8. DATE OF BIRTH July 1st 1879
9. AGE (In years last birthday) 77		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) farmer	10b. KIND OF BUSINESS OR INDUSTRY farm
11. BIRTHPLACE (City and State or Foreign Country) Greenville Ky		12. CITIZEN OF WHAT COUNTRY? U S A	

13a. FATHER'S NAME Jeff Houston	13b. MOTHER'S MAIDEN NAME unknown	14. NAME OF HUSBAND OR WIFE Louisa Houston
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no	16. SOCIAL SECURITY NO. (If yes, give war or dates of service) none	17. INFORMANT'S SIGNATURE OR NAME Beatrice Williams (daughter) ADDRESS Kansas City Mo.
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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, asphyxia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH 1 yr. 2 yrs. 442X
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cardio-Renal disease		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Hypertension DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 10-10- 1956, to 11-8- 1956, that I last saw the deceased alive on 11-8- 1956, and that death occurred at 6:00 a.m., from the causes and on the date stated above.

23a. SIGNATURE W. A. Love, M.D. (Degree or title)	23b. ADDRESS 1820 N. 3rd St.	23c. DATE SIGNED 11-12-56
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24a. BURIAL, CREMATION, REMOVAL (Specify) removal	24b. DATE Nov 12th 1956	24c. NAME OF CEMETERY OR CREMATORY Pine Bluff Cem	24d. LOCATION (City, town, or county) (State) Pine Bluff Ark
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DATE REC'D BY LOCAL REG. 11-12-56	REGISTRAR'S SIGNATURE Neva Marshall	25. FUNERAL DIRECTOR'S SIGNATURE ADKINS FUNERAL HOME ADDRESS 2000 E 12 K. C. Mo
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD
W. A. Love

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.....
W. Kenneth Reed

Licensed Embalmer No. 2161

P. O. Address.....
J. M.

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.