

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

40389

FILED DEC 2 - 1957

STATE FILE NUMBER 5222

Registration District No. 149 Primary Registration District 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 Missouri b. COUNTY Jackson		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kansas City		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN Kansas City Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Research Hosp.			Length of stay in 1b ⁷² Yrs.		d. STREET ADDRESS 4916 Paseo (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First MIDDLE Last GEORGE RAY HOUGH			4. DATE OF DEATH Month Day Year Nov. 6, 1957		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-28-1883	9. AGE (In years last birthday) 73	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Paint Contractor		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) St. Paul, Minn.	
13. FATHER'S NAME John Henry Hough			14. MOTHER'S MAIDEN NAME Elizabeth Pilger		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 487-07-0152		17. INFORMANT Address Mrs. Lila Hough K. C. Mo.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute Myocardial Infarction</i> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <i>Coronary Artery Sclerosis & Atherosclerosis</i> DUE TO (c) <i>Generalized Atherosclerosis</i>					INTERVAL BETWEEN ONSET AND DEATH <i>2 weeks</i> <i>2 years</i> <i>5 years</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Complete Bundle Branch Block - Atrophic Cardiac</i>					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT <input type="checkbox"/>	SUICIDE <input type="checkbox"/>	HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Hour Month, Day, Year a. m. p. m.					
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from <i>June 20 1952</i> to <i>Nov. 6 1957</i> and last saw <i>him</i> alive on <i>Nov. 6 1957</i> Death occurred at <i>7:30 P.</i> m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <i>Graham Asher M.D.</i>			22b. ADDRESS <i>1220 Professional Bldg. Kansas City</i>		22c. DATE SIGNED <i>6 - Nov - 57</i>
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 11-9-57	23c. NAME OF CEMETERY OR CREMATORY Forest Hill		23d. LOCATION (City, town, or county) (State) Kansas City, Mo.	
24. FUNERAL DIRECTOR Freeman Mortuary		ADDRESS K. C. Mo.		25. DATE RECD. BY LOCAL REG. 11-7-57	26. REGISTRAR'S SIGNATURE <i>Reverend Marshall</i>

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

Graham Asher

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I. must be casually related. Coroner cannot certify to a death due to natural causes.

Health, & Welfare
Public Health Service

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1-56



B. Nealman
Prof. Bldg.
2 - 5th floor
Yi-2-8180

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 *[Signature]*
Licensed Embalmer No. *479*
P. O. Address *[Signature]*

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.