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THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-008590

STATE FILE NUMBER

FILED FEB 25 1958

Registration District No. 360 Primary Registration District No. 6225 Registrar's No. 19

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1. PLACE OF DEATH a. COUNTY <u>Vernon</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Bates</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR <u>Washington Township</u> TOWNSHIP		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	c. CITY OR TOWN <u>Rich Hill</u> 0070 Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>St. Hosp. #3</u>		Length of stay in lb <u>3-4-58 to 2-18-58</u>	d. STREET ADDRESS (If outside, give location) Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Middle Last <u>WALTER SAMUEL HOUGH</u>			4. DATE OF DEATH Month Day Year <u>Feb. 18 1958</u>		
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5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Apr. 10, 1884</u>	9. AGE (In years last birthday) <u>73</u>	10. FUNDER 1 YEAR Months Days <u>10 8</u>	IF UNDER 24 HRS. Hours Min. <u>0</u>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <u>Cast Co, Mo</u>	12. CITIZEN OF WHAT COUNTRY? <u>America</u>
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13a. FATHER'S NAME <u>John H. Hough</u>	13b. MOTHER'S MAIDEN NAME <u>Rebecca Jones</u>	14. NAME OF HUSBAND OR WIFE <u>Nora Hough (Kamey)</u>
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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) <u>no</u>	16. SOCIAL SECURITY NO. <u>494-40-6895</u>	17. INFORMANT <u>Ben Hough</u> Address <u>Rich Hill, Mo, R4</u>
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 hour</u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>Bronchopneumonia</u>		<u>1 week</u>
	DUE TO (c)		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Psychosis</u>		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.) <u>491X</u>
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20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.	
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20d. INJURY OCCURRED! WHILE AT <input type="checkbox"/> NOT WHILE <input type="checkbox"/> WORK AT WORK	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION COUNTY STATE
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21. I attended the deceased from <u>Feb 4, 1958</u> to <u>Feb 18-1958</u> and last saw <u>him</u> alive on <u>Feb 18-1958</u> Death occurred at <u>7:05</u> p.m. on the date stated above; and to the best of my knowledge, from the causes stated.
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22a. SIGNATURE (Degree or title) <u>Earl F. Morris M.D.</u>	22b. ADDRESS <u>St. Hospital #3 Nevada, Mo</u>	22c. DATE SIGNED <u>2-18-1958</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>2/20/58</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Greenbarn Cemetery</u>	23d. LOCATION (City, town, or country) (State) <u>Rich Hill, Missouri</u>
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24. FUNERAL DIRECTOR <u>Earl F. Morris</u>	ADDRESS <u>Rich Hill, Mo</u>	25. DATE RECD. BY LOCAL REG. <u>2-19-1958</u>	26. REGISTRAR'S SIGNATURE <u>Anna G. Perry</u>
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(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

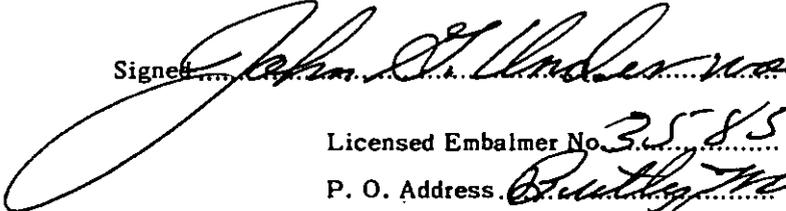
MEDICAL CERTIFICATION

Doctor, coroner, etc. must use only standard form. All diseases in Part I must be causally related.

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 

Licensed Embalmer No. 3585

P. O. Address. 

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.