

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-023400  
STATE FILE NUMBER  
6129

FILED JUN 27 1958 Registration District No. 318 Primary Registration District No. 1003 Registrar's No.

S. 300  
-1-57

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>JEFFERSON</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>ST. LOUIS Mo.</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>DE SOTO</u> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Mo. PACIFIC Hosp.</u>		Length of stay in 1b	d. STREET ADDRESS (If outside, give location) <u>29 ROUTE # 2</u> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Middle Last <u>MIRIAM T. HOUGHEN</u>			4. DATE OF DEATH Month Day Year <u>JUNE 13 1958</u>		
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>MAR. 6, 1891</u>	9. AGE (In years last birthday) <u>67</u>	IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED CHAM SHELL OPER.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Mo. PAC. R.R.</u>	11. BIRTHPLACE (City and state or country) <u>Mo.</u>	12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	

13a. FATHER'S NAME <u>JAMES HENRY HOUGHEN</u>		13b. MOTHER'S MAIDEN NAME <u>SARAH E. BARKER</u>		14. NAME OF HUSBAND OR WIFE <u>METTIE HOUGHEN</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or unknown) (If yes, give year for start of service) <u>Yes WWII</u>		16. SOCIAL SECURITY NO. <u>UNKNOWN</u>	17. INFORMANT Address <u>METTIE HOUGHEN RT 2 DeSoto, Mo.</u>		

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>Acute Stenosis</u>		INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) <u>42.1</u>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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 <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 \_\_\_\_\_ to \_\_\_\_\_ and last saw <sup>her</sup>/<sub>him</sub> alive on \_\_\_\_\_  
Death occurred at 320A \_\_\_\_\_ m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Deceased or title) <u>Patrick Taylor Corcoran</u>	22b. ADDRESS <u>1300 Clark</u>	22c. DATE SIGNED <u>6.16.58</u>
--	-----------------------------------	------------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE <u>JUNE 16, 1958</u>	23c. NAME OF CEMETERY OR CREMATORY <u>NATIONAL Cem.</u>	23d. LOCATION (City, town, or county) (State) <u>JEFFERSON BRKS. Mo</u>
---	-----------------------------------	--	--

24. FUNERAL DIRECTOR <u>Thomas Kutia</u>	ADDRESS <u>2906 Gravois</u>	25. DATE RECD. BY LOCAL REG. <u>JUN 16 58</u>	26. REGISTRAR'S SIGNATURE <u>J. Carl Smith, M.D.</u>
---	--------------------------------	--	---

(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 nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

S.P.

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 *Leo J. Budde* .....  
Licensed Embalmer No. *3989* .....  
P. O. Address *St. Louis* .....

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.