

R I DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-032988

FILED VS OCT 5 1959

385 Primary Registration District No. 3039 Registrar's No. 74

STATE FILE NUMBER

DED

1. PLACE OF DEATH a. COUNTY Linn		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Macon	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Marceline		Length of stay in 1b 6yrs.	c. CITY OR TOWN New Cambria Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Francis hospital		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 3 miles S. New Cambria Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Middle Last Theodore M. Houghton			4. DATE OF DEATH Month Day Year September 19, 1959			
---	--	--	---	--	--	--

5. SEX Male	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 12/12/71	9. AGE (last birthday) 87	IF UNDER 1 YEAR Months 9 Days 7	IF UNDER 24 HR Hours 7 Min.
-----------------------	----------------------------------	---	-------------------------------------	-------------------------------------	--	---------------------------------------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farming	10b. KIND OF BUSINESS OR INDUSTRY Own farm	11. BIRTHPLACE (City and state or country) New Cambria (Rural)	12. CITIZEN OF WHAT COUNTRY U.S.
---	--	--	--

13a. FATHER'S NAME James H. Houghton	13b. MOTHER'S MAIDEN NAME Julia Mason	14. NAME OF HUSBAND OR WIFE -----
--	---	--------------------------------------

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. 492 42 6751	17. INFORMANT Records	Address
--	---	---------------------------------	---------

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Diabetic coma		INTERVAL BETWEEN ONSET AND DEATH approx 15 hrs
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) Septicemia following a wound infection (wound)	
	DUE TO (c) Ruptured Gall Bladder	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) arteriosclerosis, cardiovascular disease; diabetes, hepatitis, gangrene of legs.		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
--	--	--	--

19. WAS AUTOPSY PERFORMED? YES <input 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 _____ a.m. _____ p.m. Month, Day, Year	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 1954 to 9-18-59 and last saw ^{him} alive on 9-19-59 Death occurred at _____ m on the date stated above, and to the best of my knowledge, from the causes stated.
--

22a. SIGNATURE (Degree or title) James Houghton	22b. ADDRESS Marceline Missouri	22c. DATE SIGNED 9-21-59
---	---	------------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 9/22/59	23c. NAME OF CEMETERY OR CREMATORY New Cambria Cemetery	23d. LOCATION (City, town, or county) (State) New Cambria, Mo.
--	-----------------------------	---	--

24. FUNERAL DIRECTOR H. H. Hilleland	ADDRESS New Cambria Mo	25. DATE RECD. BY LOCAL REG. 9-21-59	26. REGISTRAR'S SIGNATURE Brookie Owens
--	----------------------------------	--	---

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1958 & ADM

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by _____ or by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed

Gerald F. Wad

Licensed Embalmer No. 4272

P. O. Address Brown

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to conform 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.