

FEDERAL BUREAU OF INVESTIGATION
 U.S. DEPARTMENT OF JUSTICE
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59-041270

FILED VS DEC 7 1959

STATE FILE NUMBER

Registration District No. 276 Primary Registration District No. 4900 Registrar's No. 42

ENDED

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| 1. PLACE OF DEATH a. COUNTY <u>Phelps</u> | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MO.</u> b. COUNTY <u>Phelps</u> | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>ST. JAMES</u> | Length of stay in 1b <u>25 yrs.</u> | c. CITY OR TOWN <u>ST. JAMES</u> | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>✓</u> | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | d. STREET ADDRESS (If outside, give location) <u>✓</u> |
| | | | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |

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| 3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>F.</u> Last <u>HOUK</u> | | | 4. DATE OF DEATH Month <u>11</u> Day <u>28</u> Year <u>'59</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>4-3-1882</u> | 9. AGE (last birthday) <u>77</u> | IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Insurance Office</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>✓</u> | 11. BIRTHPLACE (City and state or country) <u>HANCOCK, MO.</u> | | 12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u> | |
| 13a. FATHER'S NAME <u>H.C. HOUK</u> | | 13b. MOTHER'S MAIDEN NAME <u>Pellina Rhea</u> | | 14. NAME OF HUSBAND OR WIFE <u>Elsie HOUK</u> | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>✓</u> | | 16. SOCIAL SECURITY NO. <u>494-38-0800</u> | 17. INFORMANT <u>Elsie HOUK - wife</u> Address | | | |

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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>sudden</u> |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) | | PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown |

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| 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 _____ a.m. _____ p.m. _____ | | |

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|---|--|------------------------------------|--------------|-------------|
| 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 <u>11-26-59</u> to <u>11-28-59</u> and last saw ^{her} him alive on <u>11-28-59</u> Death occurred at <u>10 am</u> on the date stated above, and to the best of my knowledge, from the causes stated. | | | | |

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| 22a. SIGNATURE <u>J. W. Stricker M.D.</u> (Degree or title) | | 22b. ADDRESS <u>St James MO</u> | | 22c. DATE SIGNED <u>12-1-59</u> |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | 23b. DATE <u>11-30-59</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>MASONIC Cem.</u> | 23d. LOCATION (City, town, or county) (State) <u>ST. JAMES, MO.</u> | |

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| 24. FUNERAL DIRECTOR <u>Dr. E. Dickler - St James, MO</u> ADDRESS | 25. DATE RECD. BY LOCAL REG. <u>12-1-1959</u> | 26. REGISTRAR'S SIGNATURE <u>Ruth B. Powell</u> | |
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(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

MS DEC 6 1959

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 Orrel E. Lieklich

Licensed Embalmer No. 354

P. O. Address St. James

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.