

**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

Do not use this space.

28097

1. PLACE OF DEATH

County St. Louis Henry
Township _____
City Calhoun (No. _____) St. _____ Ward _____

Registration District No. 344
Primary Registration District No. 4207

File No. _____
Registered No. 24

2. FULL NAME

Margaret Lee Parr Houston

(a) Residence, No. _____ St. _____ Ward _____
(Usual place of abode) (If nonresident, give city or town and State)

Length of residence in city or town where death occurred 21 yrs. - mos. - ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Married

6. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Herbert Houston

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Dec 3, 1909

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day,hrs. ormin.
	<u>21</u>	<u>7</u>	<u>28</u>	

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Home wife
9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. _____
10. Date deceased last worked at this occupation (month and year) _____ 11. Total time (years) spent in this occupation _____

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Calhoun Mo

13. NAME W A Parr

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ohio

15. MAIDEN NAME Anna Lee Guttridge

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Calhoun Mo

17. INFORMANT M A Parr (ADDRESS) Calhoun Mo

18. BURIAL, CREMATION, OR REMOVAL PLACE Calhoun Cemetery DATE Aug 3, 1931

19. UNDERTAKER J A Housey (ADDRESS) Calhoun Mo

20. FILED Aug 2, 1931 Mrs. A. A. Gray Registrar.

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Aug 1, 1931

22. I HEREBY CERTIFY, That I attended deceased from June 26, 1931, to Aug 1, 1931. I last saw her alive on Aug 1, 1931. Death is said to have occurred on the date stated above, at 8, 9 a.m.

The principal cause of death and related causes of importance were as follows:
Colloid Cancer of the Liver & Viscera

Other contributory causes of importance: none

Name of operation none Date of _____
What test confirmed diagnosis? _____ Was there an autopsy? _____

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? _____ Date of injury _____, 19____
Where did injury occur? _____ (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place. _____

Manner of injury ✓
Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? no
If so, specify _____
(Signed) D A Pollard M. D.
(Address) Calhoun Mo

SEP 22 1931

100

100

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ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County Henry Registration District No. 349 File No.
 Township Primary Registration District No. 4207 Registered No. 24
 City Calhoun (No.) St. Ward)

2. FULL NAME Majorie Lee T. Houston

(a) Residence. No. St. Ward.
 (Usual place of abode) (if nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED M (write the word)

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
 (a) Trade, profession, or particular kind of work
 (b) General nature of industry, business, or establishment in which employed (or employer)
 (c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY)

14. INFORMANT (Address)

15. FILED Oct 3, 1921 Miss A. A. Gray REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Aug 1 19 21

17. I HEREBY CERTIFY That I attended deceased from 19..... to 19..... that I last saw h..... alive on 19....., and that death occurred, on the date stated above, at..... m.

THE CAUSE OF DEATH WAS AS FOLLOWS:
Cultured cancer of the liver & dissection of liver
 (duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) 4-6-20 (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED
 IF NOT AT PLACE OF DEATH.....

DID AN OPERATION PRECEDE DEATH?..... DATE OF.....

WAS THERE AN AUTOPSY?.....

WHAT TEST CONFIRMED DIAGNOSIS?
 (Signed) D. A. Ballard, M. D.
 , 19 - (Address) Calhoun Mo.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL DATE OF BURIAL 19.....

20. UNDERTAKER ADDRESS

REGIS 349 VAL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

SUPPLEMENTARY

5-28097