FILED FEB 17 1941

No. ...
...13-4...
...17-39

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 3357

Registration District No. 534 Primary Registration District No. 5314 Registrar's No. 22

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:
(a) County Macon
(b) City or town Rural ... (If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: ...
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution ...
In this community All his Life (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo (b) County Macon
(c) City or town Rural (If outside city or town limits, write "RURAL")
(d) Street No. — (If rural, give location)
(e) If foreign born, how long in U. S. A.? — 0 years.

3. (a) PRINT FULL NAME Loralon Prentice Houghton

3. (b) If veteran, name war [redacted]
3. (c) Social Security No. —

4. Sex Male
5. Color or race White
6. (a) Single, widowed, married, divorced Single
6. (b) Name of husband or wife —
6. (c) Age of husband or wife if alive — years
7. Birth date of deceased Sept 13 1874 (Month) (Day) (Year)

8. AGE: Years 66 Months 4 Days 3 If less than one day ... hr. ... min.

9. Birthplace Macon Co Mo (City, town, or county) State (State or foreign country)
10. Usual occupation Farmer
11. Industry or business ...

FATHER
12. Name James Hazel Houghton
13. Birthplace New York (City, town, or county) New York (State or foreign country)

MOTHER
14. Maiden name Julia Mason
15. Birthplace Cleveland (City, town, or county) Ohio (State or foreign country)

16. (a) Informant Theodore Houghton
(b) Address New Cambria Mo

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 18-1940 (Month) (Day) (Year)
(c) Place: burial or cremation New Cambria Cemetery
18. (a) Signature of funeral director W. J. Gilliland
(b) Address New Cambria Mo
19. (a) Feb 8-1941 (Date received local registrar) (b) [redacted] O. O. West (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 16
year 1940 hour 6 minute a M.

21. I hereby certify that I attended the deceased from
Jan 1st, 1940, to Dec 13, 1940
that I last saw him alive on Dec 13, 1940
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Tuberculosis of Throat	1 yr
Due to —	
Due to —	
Other conditions — (Include pregnancy within 3 months of death)	
Major findings: Of operations no	
Of autopsy no	

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) —
(b) Date of occurrence ...
(c) Where did injury occur? ... (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? — (Specify type of place)
While at work? ... (e) Means of injury —

23. Signature O. O. West (M. D. or other)
Address New Cambria, Mo Date signed Dec 18/1940

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 10
District File Number 2-41-280
Date Filed FEB 13 1941

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~~ H. J. Gilleland, Registered Apprentice No. .....
working under my personal supervision.

Signed H. J. Gilleland

Licensed Embalmer No. 4019

P. O. Address New Cambria, Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wit the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

No. 2B
4-25-41
I X27852

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 3317

Registration District No. 534 Primary Registration District No. 5717 Registrar's No. 22

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

MOORE

1. PLACE OF DEATH:

(a) County Macon (b) ~~City or town~~ Long T.P.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution (Specify whether M or F)
In this community
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State (b) County
(c) City or town
(If outside city or town limits, write "RURAL")
(d) Street No.
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Loreans Prentice Houghton

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex M

5. Color or race W

6. (a) Single, widowed, married, divorced S

6. (b) Name of husband or wife

6. (c) Age of husband or wife if alive years

7. Birth date of deceased (Month) (Day) (Year)

8. AGE: Years 66 Months 4 Days 3 If less than one day hr. min.

9. Birthplace (City, town, or county) (State or foreign country)

10. Usual occupation

11. Industry or business

MOTHER FATHER

12. Name

13. Birthplace (City, town, or county) (State or foreign country)

14. Maiden name

15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant

(b) Address

17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)

(c) Place: burial or cremation

18. (a) Signature of funeral director

(b) Address

19. (a) (Date received local registrar) (b) (Registrar's signature)

SUPPLEMENTARY

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 16
year 1940 hour minute M.

21. I hereby certify that I attended the deceased from , 19, to , 19; that last saw h alive on , 19; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death	
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations	
Of autopsy	

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify)

(b) Date of occurrence

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)

While at work? (e) Means of injury

23. Signature O. O. West (M. D. or other)

Address New Cambria Date signed