

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

Do not use this space.

28576

1. PLACE OF DEATH

County Phelps
Township _____
City Rolla (No. _____)

Registration District No. 677
Primary Registration District No. 4403

File No. _____
Registered No. 92
St. _____ Ward _____

2. FULL NAME

Samuel Houghton
(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 M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Widower

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Don't know

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, _____ hrs. or _____ min. 52

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

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

10. NAME OF FATHER Thos. Houghton

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

12. MAIDEN NAME OF MOTHER Ellen

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

14. INFORMANT Mrs. Nellie Gibson (Address) Lacoma, Mo

15. FILED Aug 30, 1929 Joe F. Myers REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 8/30/29

17. I HEREBY CERTIFY, That I attended deceased from _____, 19____, to death, 19____, that I last saw him alive on 1st, 19____, and that death occurred, on the date stated above, at 5:15 a. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
mitral regurgitation

CONTRIBUTORY (SECONDARY) 92 A (duration) yrs. mos. ds. 90 W (duration) yrs. mos. ds.

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

18 DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____ WAS THERE AN AUTOPSY? _____

WHAT TEST CONFIRMED DIAGNOSIS? (Signed) P. Sidney McFarland M. D. 8/30, 1929 (Address) Rolla, 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 St. Louis, Mo. DATE OF BURIAL Aug 31, 1929

20. UNDERTAKER Null & Dickler ADDRESS Rolla, Mo.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

MISSOURI STATE BOARD OF HEALTH BUREAU OF VITAL STATISTICS

81
2
4
2

8

PARENTS

