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

Do not use this space.

41358

File No.

Registered No. 14

PLACE OF DEATH

County Macon Registration District No. 534

Township Liggin Primary Registration District No. 5717

City (No. , St., Ward)

2. FULL NAME William A. H. Houghton

(a) Residence. William J. A. Houghton St., Ward.
(Usual place of abode)

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.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

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

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) April 20-1861

7. AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	68	7	26	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Farmer

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

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

PARENTS

10. NAME OF FATHER James H. Houghton

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

12. MAIDEN NAME OF MOTHER Julia Moon

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

14. INFORMANT Mrs Mary Houghton
(Address) New Cambria Mo

15. FILED 12-17, 1929 G.T. Eunday REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Dec 16th 1929

17. I HEREBY CERTIFY, That I attended deceased from Sept 21, 1929 to Dec 15, 1929 that I last saw him alive on Dec 15, 1929, and that death occurred, on the date stated above, at 6 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Cirrhosis of the Liver

1 yr.

(duration) 1 yrs. — mos. — ds.

CONTRIBUTORY (SECONDARY) —

(duration) — yrs. — mos. — ds.

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

DID AN OPERATION PRECEDE DEATH? No DATE OF —

WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS? —

(Signed) O. O. West, M. D

Dec 18, 1929 (Address) New Cambria 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
New Cambria Country	Dec 17 1929
20. UNDERTAKER	ADDRESS
J. E. Gilleland	New Cambria Mo

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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.