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.

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

PLACE OF DEATH

County Shelby

Township ~~Black Creek~~ Registration District No. 831 File No. 4323

or Village Primary Registration District No. 4504 Registered No. 1

or City Shelbyville (NO. ____ St.: ____ Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME John B. Houts

PERSONAL AND STATISTICAL PARTICULARS

SEX: Male

COLOR OR RACE: White

SINGLE MARRIED WIDOWED OR DIVORCED (Write the word): Widowed

DATE OF BIRTH: June (Month) 8 (Day), 1849 (Year)

AGE: 69 yrs. 6 mos. 23 ds. If LESS than 1 day, ___ hrs. or ___ min.?

OCCUPATION
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer):

BIRTHPLACE (City or town, State or foreign country): Illinois

PARENTS
NAME OF FATHER: Peter Houts
BIRTHPLACE OF FATHER (City or town, State or foreign country): Pa.
MAIDEN NAME OF MOTHER: Could not find out
BIRTHPLACE OF MOTHER (City or town, State or foreign country): Not known

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) George Houts

(ADDRESS) Shelbina Mo

Filed Jan 1, 1917. Wm Carson REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH: Jan. (Month) 1 (Day), 1917 (Year)

I HEREBY CERTIFY, that I attended deceased from Dec. 30, 1916, to ——, 191—, that I last saw him alive on Dec 30, 1916, and that death occurred, on the date stated above, at 7-30 A.M.

The CAUSE OF DEATH* was as follows:

Shock following Convulsion

85
87B

69

(Duration) ___ yrs. ___ mos. ___ ds.

Contributory (SECONDARY) Epilepsy

(Duration) 5 yrs. ___ mos. ___ ds.

(Signed) C E Salyer M. D.

1/1, 1917 (Address) Shelbyville Mo

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) Co Infirmary

At place of death ___ yrs. 6 mos. ___ ds. In the State ___ yrs. 6 mos. ___ ds.

Where was disease contracted if not at place of death? X

Former or usual residence Shelbina Mo

PLACE OF BURIAL OR REMOVAL: Shelbina Mo

DATE OF BURIAL: Jan. 2, 1917

UNDERTAKER: J. N. Thompson Son

ADDRESS: Shelbyville, Mo.

Revised United States Standard Certificate of Death

[Approved by U. S. Census and American Public Health Association.]

"Typhoid pneumonia"); *Lobar pneumonia; Broncho-pneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum,* etc., *Carcinoma, Sarcoma,* etc., of.....(name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis,* etc. The contributory (secondary or in-

MISSOURI STATE BOAR
BUREAU OF VITAL ST
CERTIFICATE OF D

PLACE OF DEATH

County.....

Township ..... Registration District No..... File No.....
or
Village..... Primary Registration District No..... Registered No.....
or
City .....(NO....., ...St.;.....Ward)

FULL NAME.....

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	SINGLE MARRIED WIDOWED OR DIVORCED (*Write* the word)

DATE OF BIRTH

....., 1.....
(Month) (Day) (Year)

AGE

.....yrs.....mos.....ds.

If LESS than 1 day, ...hrs. or....min.?

OCCUPATION
(a) Trade, profession, or particular kind of work .....

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

BIRTHPLACE
(City or town, State or foreign country)

PARENTS

NAME OF FATHER

BIRTHPLACE OF FATHER
(City or town, State or foreign country)

MAIDEN NAME OF MOTHER

BIRTHPLACE OF MOTHER
(City or town, State or foreign country)

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant).....

(ADDRESS).....

Filed ....., 191...., ...
REGISTRAR

MEDICAL CERTIFICATE OF DE

DATE OF DEATH

.....
(Month)

I HEREBY CERTIFY, that I atte
....., 191...., to.....
that I last saw h.....alive on.....
and that death occurred, on the date stated
The CAUSE OF DEATH* was as follows:

.....

.....

.....

.....(Duration).....yrs.....

Contributory.....
(SECONDARY)

.....(Duration).....yrs.....

(Signed).....

....., 191.... (Address).....

*State the Disease Causing Death, or, in deaths fr
(1) Means of Injury: and (2) whether Accidental, Suicidal, o

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITU
RECENT RESIDENTS)

At place of death.....yrs.....mos.....ds. In the State.....yr

Where was disease contracted if not at place of death?.....

Former or usual residence.....

PLACE OF BURIAL OR REMOVAL	DA
UNDERTAKER	AD