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.

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH 26732

PLACE OF DEATH

County New Madrid

Township Portage

or

Village Portageville

or

City _____ (NO. _____ St.; _____ Ward)

Registration District No. 607 File No. 16

Primary Registration District No. 5806 Registered No. _____

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

FULL NAME Thelma Huffman

PERSONAL AND STATISTICAL PARTICULARS

SEX: female

COLOR OR RACE: w

SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): single

DATE OF BIRTH: December 1, 1922 (Month) (Day) (Year)

AGE: 1 yrs. 7 mos. 14 ds. If LESS than 1 day, ___ hrs. or ___ min.?

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

(b) General nature of industry, business, or establishment in which employed (or employer): 118

BIRTHPLACE (City or town, State or foreign country): Mathews Mo

PARENTS

NAME OF FATHER: E A Huffman

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

MAIDEN NAME OF MOTHER: Anna Suter

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

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) E A Huffman

(ADDRESS) Portageville Mo

Filed 10-2, 1924 R K Miller REGISTRAR

MEDICAL CERTIFICATE OF DEATH

3

DATE OF DEATH: 9 (Month) 15 (Day), 1924 (Year)

I HEREBY CERTIFY, that I attended deceased from Sept 2, 1924 to Sept 15, 1924 that I last saw her alive on Sept 15, 1924 and that death occurred, on the date stated above, at 8 a.m.

The CAUSE OF DEATH* was as follows:

Congestion of Stomach and Bowels 113

(Duration) ___ yrs. ___ mos. 14 ds.

Contributory (SECONDARY) Teething and Diarrhoea

(Duration) ___ yrs. ___ mos. 14 ds.

(Signed) H A Keeran M. D.

9-15, 1924 (Address) Portageville

*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)

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

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

Former or usual residence _____

PLACE OF BURIAL OR REMOVAL: Maynard Cemetery

DATE OF BURIAL: 9-16, 1924

UNDERTAKER: R D Young

ADDRESS: Portageville Mo

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

PLACE OF DEATH

County.....

Township ..... Registration District No. ..... File No. .....

or

Village..... Primary Registration District No. ..... Registered No. .....

or

City ..... (NO. .... St.: ..... Ward)

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

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 DEATH

DATE OF DEATH

..... , 191.....
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from ..... , 191..... , to ..... , 191..... , that I last saw h..... alive on ..... , 191..... ; and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

.....

.....

.....

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

Contributory
(SECONDARY)
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.

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

*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)

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

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

Former or usual residence .....

PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL ..... , 191.....
UNDERTAKER	ADDRESS

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

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