

22 1928

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

Do not use this space.

29764

1. PLACE OF DEATH

County Buchanan
Township St. Joseph
City St. Joseph

Registration District No. 85
Primary Registration District No. 1001

File No. _____
Registered No. 1070
St. _____ Ward _____

2. FULL NAME

(a) Residence. No. 601219-23 St. _____ Ward _____
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred 25 yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

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

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Juanita Huff

6. DATE OF BIRTH (MONTH, DAY AND YEAR) March 12 1849

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
79 5 27

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

9. BIRTHPLACE (CITY OR TOWN) Lutes Co.
(STATE OR COUNTRY) _____

10. NAME OF FATHER John Huff

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

12. MAIDEN NAME OF MOTHER Unknown

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

14. INFORMANT J. D. Clark
(Address) 5025 King Hill

15. FILED 9/11 1928 John G. Webb REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Sept 9 1928

17. I HEREBY CERTIFY, That I attended deceased from Jan 25 1925, to Sept 9 1928, and that I last saw him alive on Sept 9 1928, and that death occurred, on the date stated above, at 9:00 P. M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Cerebral Hemorrhage
82A
72D

CONTRIBUTORY (SECONDARY) Paralysis (duration) _____ yrs. _____ mos. _____ da.
Four (duration) 4 yrs. _____ mos. _____ da.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH: at home

DID AN OPERATION PRECEDE DEATH? no DATE OF _____

WAS THERE AN AUTOPSY? no
WHAT TEST CONFIRMED DIAGNOSIS? Clinical
(Signed) Dr. C. W. Cooper, M. D.
9/11 1928 (Address) 2214 Kirkpatrick Bldg

*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 Mt. Mora DATE OF BURIAL Sept 11 1928

20. UNDERTAKER W. D. Clark ADDRESS 5025 King Hill Av.

WRITE CLEARLY, 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.

