

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

Do not use this space.

4480

1. PLACE OF DEATH

County.....
Township.....
City..... *St Louis Mo* (No. *791*)

Registration District No. *791*
Primary Registration District No. *1003*

File No.....
Registered No. *1146*
St. Ward)

2. FULL NAME

Herman, Daniel Huffing
(a) Residence. No. *Warsaw Mo* St. *12* Ward.

Warsaw Mo
(If nonresident give city or town and State)

Length of residence in city or town where death occurred 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 *married*

5A. IF MARRIED, WIDOWER, OR DIVORCED HUSBAND OF (OR) WIFE OF *Virginia Huffing*

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *Aug 18 1881*

7. AGE YEARS MONTHS DAYS | IF LESS than 1 day, hrs. or min.
47 | 5 | 4

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

9. BIRTHPLACE (CITY OR TOWN) *Ky*
(STATE OR COUNTRY)

10. NAME OF FATHER *Joe D Huffing*

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

12. MAIDEN NAME OF MOTHER *Lucinda Saddle*

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

14. INFORMANT *Thos A Huffing*
(Address) *Warsaw Mo*

15. FILED *23 1929* REGISTRAR *Max C. ...*

MEDICAL CERTIFICATE OF DEATH

2
16. DATE OF DEATH (MONTH, DAY AND YEAR) *1-22-1929*

17. I HEREBY CERTIFY, That I attended deceased from *1-14*, 19*29*, to *1-22*, 19*29*.
(that I last saw him *in* alive on *1-22*, 19*29*, and that death occurred, on the date stated above, at *6:45 a.m.*)

THE CAUSE OF DEATH* WAS AS FOLLOWS:

82A Cerebral Hemorrhage
102 Hypertension
(duration) yrs. mos. da.

CONTRIBUTORY (SECONDARY) *7/11/01*
(duration) yrs. mos. da.

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

0 DID AN OPERATION PRECEDE DEATH? *no* DATE OF

WAS THERE AN AUTOPSY? *no*

WHAT TEST CONFIRMED DIAGNOSIS?
(Signed) *D. Bannister* M. D.

Jan 23, 1929 (Address) *Barnes Hosp.*

*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 *Bedford Mo* DATE OF BURIAL *1/23 1929*

20. UNDERTAKER *A Ellis & no Delmar*
ADDRESS

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.

1929
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2
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