

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

Do not use this space.
Grouway
22029

1. PLACE OF DEATH

County *Macon*
Township *Hudson*
City *No.*

Registration District No. *533*
Primary Registration District No. *5713*

File No. _____
Registered No. *23*
St. _____ Ward)

2. FULL NAME

David B. Huffman

(a) Residence. No. _____ 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 *Male* 4. COLOR OR RACE *White* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED *married*

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF *Lizzie Huffman*

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *Apr 14, 1863*

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
66 1 8

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) (STATE OR COUNTRY) *Herrin, Illinois*

10. NAME OF FATHER *Cornelius Huffman*

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

12. MAIDEN NAME OF MOTHER *Lena Couner*

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) *Summerville New Jersey*

14. INFORMANT (Address) *Mrs Lizzie Huffman, Macon Mo R. #2*

15. FILED *6/30 29* REGISTRAR *Mrs Luke Yunkler*

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *6-22 1929*

17. I HEREBY CERTIFY, That I attended deceased from *6-10*, 19*28* to *6-22*, 19*29*
that I last saw him alive on *6-21*, 19*29* and that death occurred, on the date stated above, at _____ m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

*131 Cardio Vascular
988 Renal disease*

CONTRIBUTORY (SECONDARY) *gouty toph*
(duration) yrs. mos. ds. *3*

18. WHERE WAS DISEASE CONTRACTED *129th St*
IF NOT AT PLACE OF BIRTH _____

2 DID AN OPERATION PRECEDE DEATH? *yes* DATE OF *5-20-29*
WAS THERE AN AUTOPSY? *no*

WHAT TEST CONFIRMED DIAGNOSIS?
(Signed) *P. P. Grouway*
6-23 29 (Address) *Macon 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. *removal*

19. PLACE OF BURIAL, CREMATION, OR REMOVAL (DATE OF BURIAL) *Stremout, Nebraska June 23 1929*

20. UNDERTAKER (ADDRESS) *Albert Skinner Macon Mo*

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.

DEATH RECORD

1

2

61
26 1929

