

OCT 3 0 1935

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

Do not use this space.

32146

1. PLACE OF DEATH

County Cass
Township
City Harrisonville (No. _____)

Registration District No. 156
Primary Registration District No. 4090

File No. _____
Registered No. 47
St. _____ Ward)

2. FULL NAME William Huffman

(a) Residence, No. _____ St. _____ Ward. _____

(Usual place of abode) (If nonresident, give city or town and State)
Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>Male</u>	4. COLOR OR RACE <u>White</u>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <u>Widowed</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <u>Catherine Huffman</u>		
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <u>Mar 22 - 1875</u>		
7. AGE YEARS <u>90</u>	MONTHS <u>6</u>	DAYS <u>12</u>
8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. <u>farmer - Retired</u>		
9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.		
10. Date deceased last worked at this occupation (month and year)		11. Total time (years) spent in this occupation

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Oct 4, 1935

22. HEREBY CERTIFY, That I attended deceased from Sept 29, 1935 to Oct 4, 1935.
I last saw him alive on Oct 3, 1935. Death is said to have occurred on the date stated above, at 3:45 P.M.

The principal cause of death and related causes of importance were as follows:
Uraemic Coma with chronic nephritis

Date of onset

Other contributory causes of importance:

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ohio

FATHER

13. NAME Joseph Huffman

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ohio

MOTHER

15. MAIDEN NAME Susan Brady

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Tennessee

17. INFORMANT (ADDRESS) Ohio E. Martinson Harrisonville Mo

18. BURIAL, CREMATION, OR REMOVAL PLACE Orient Cemetery DATE 10/5/35

19. UNDERTAKER (ADDRESS) Quinnenburg Bros 510 Harrisonville Mo

20. FILED Oct 5, 1935 Tom Grogan Registrar.

Name of operation _____ Date of _____

What test confirmed diagnosis? _____ Was there an autopsy? _____

23. If death was due to external causes (violence), fill in also the following: Accident, suicide, or homicide? _____ Date of injury _____, 19____
Where did injury occur? _____ (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury _____
Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? If so, specify _____
(Signed) J. A. Scott M. D.
(Address) Harrisonville 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.

