

Oct 16 1936

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

Do not use this space.

37339

1. PLACE OF DEATH

County Greene
Township Boone
City Ash Grove,

Registration District No. 316
Primary Registration District No. H191
(No. 316)

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

2. FULL NAME John Herman Huckshorn,

(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 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, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Emma Huckshorn,

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 4/10/1859

7. AGE # YEARS MONTHS DAYS IF LESS than 1 day, _____ hr. or _____ min.
77 77 5 24

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

9. BIRTHPLACE (CITY OR TOWN) Brunswick,
(STATE OR COUNTRY)

10. NAME OF FATHER Herman Huckshorn,

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

12. MAIDEN NAME OF MOTHER America Fox

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

14. INFORMANT Roy Huckshorn,
(Address) Ossawatimie, Kans.

15. FILED 10/5 1936 Miss Leonard Jones
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 10/4 1936

17. I HEREBY CERTIFY, That I attended deceased from _____, 1936, to Oct 4, 1936, that I last saw him alive on Oct 5, 1936, and that death occurred, on the date stated above, at 11:15 a.m.

THE CAUSE OF DEATH WAS AS FOLLOWS:
Chronic degenerative myocarditis

(duration) 28.3 yrs. mos. da.
CONTRIBUTORY (SECONDARY) Generalized arteriosclerosis
(duration) several yrs. mos. da.

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

DID AN OPERATION PRECEDE DEATH? no DATE OF _____

WAS THERE AN AUTOPSY? no
WHAT TEST CONFIRMED DIAGNOSIS Clinical
(Signed) Charles H. Gottlieb, M.D.

10-5-1936 (Address) Ash Grove 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.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Ash Grove Cemetery, DATE OF BURIAL 10/6 1936

20. UNDERTAKER A. Galbraith ADDRESS Ash Grove 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.

