

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.

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

25786
Do not use this space.

AUG 22 1939

1. PLACE OF DEATH
 (a) County Jackson Registration District No. 998
 (b) Township _____ Primary Registration District No. 3019 Registered No. 216
 (c) City Independence (d) Street No. Independence San St. _____
 (If death occurred in Hospital or Institution, write its name instead of street and number)
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.
 2. PRINT FULL NAME John T. Huffman
 (a) Residence, No. 3064 No. 36 Street St. (If nonresident, give city or town and State)
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Married
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE Mrs. Lenette Huffman
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Feb. 8, 1873
 7. AGE YEARS 66 MONTHS 3 DAYS 29 If LESS than 1 day, _____ hrs. or _____ min.
 OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Retired
 9. Industry or business in which work was done, as saw mill, bank, etc. Carpenter
 10. Date deceased last worked at this occupation (month and year) _____ Total time (years) spent in this occupation _____
 12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Kansas
 FATHER 13. NAME James Huffman
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Indiana
 MOTHER 15. MAIDEN NAME Mary Sewcett
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Indiana
 17. INFORMANT (ADDRESS) Mrs. Lenette Huffman, Kansas City, Mo.
 18. BURIAL, CREMATION OR REMOVAL PLACE St. Hope DATE July 10, 1939
 19. FUNERAL DIRECTOR (ADDRESS) Geo. C. Carson, Independence, Mo.
 20. FILED July 11, 1939 F. L. Cook, Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) July 7, 1939
 22. I HEREBY CERTIFY That I attended deceased from _____, 19____, to _____, 19____. I last saw _____ on _____, 19____. Death is said to have occurred on the date stated above, at _____ P. M. The principal cause of death and related causes of importance were as follows:
Heart Failure
Pulmonary Hemorrhage & Congestion
 Date of onset _____
 Other contributory causes of importance: _____
 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) Russell W. Fox, M. D.
 (Address) 365

STATEMENT BY LICENSED EMBALMER

I,, Licensed Embalmer No.....
hereby certify that the body recorded on the reverse side of this certificate was embalmed by.....
..... L. E.
No..... or by....., Registered Apprentice No.....
working under my personal supervision.

Signed.....

Licensed Embalmer No.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

FILL IN ANSWERS TO ALL SPACES
CHECKED IN RED PENCIL.

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

257867
Do not use this space.

1. PLACE OF DEATH

(a) County Jackson Registration District No. 398
(b) Township Independence Primary Registration District No. 2019 Registered No. _____
(c) City Independence, Street No. _____ St. _____
(If death occurred in Hospital or Institution, write its name instead of street and number)
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

(a) Residence, No. Jas. H. Huffman St. (If nonresident, give city or town and State)
(Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) M

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

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

7. AGE YEARS 66 MONTHS 3 DAYS 29 If LESS than 1 day, _____ hrs. or _____ min.

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.

9. Industry or business in which work was done, as saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

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

13. NAME

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

15. MAIDEN NAME

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

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL

PLACE _____ DATE _____, 19__

19. FUNERAL DIRECTOR (ADDRESS)

20. FILED _____, 19__

Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) July 7 1929

22. I HEREBY CERTIFY, That I attended deceased from _____, 19__ to _____, 19__

I last saw h. _____ alive on _____, 19__. Death is said to have occurred on the date stated above, at _____ m.

The principal cause of death and related causes of importance were as follows:

Heart Prostration
Pulmonary Hemorrhage
Stenosis
Other contributory causes of importance: N. M. D. # 191

Date of onset

Name of operation _____ Date of _____
What test confirmed diagnosis? _____ Was there an autopsy yes

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) Russell W. Kern, M. D.
(Address) 1827 E. 59 St. K. C. Mo

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.
CAUSE OF DEATH IN plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.
AGE should be stated EXACTLY. PHYSICIANS SHOULD SIGN.

SUPPLEMENTARY

FILL IN ANSWERS TO ALL SPACES
CHECKED IN RED PENCIL.

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

25-786
Do not use this space.

1. PLACE OF DEATH

(a) County Jackson Registration District No. 398
(b) Township Independence Primary Registration District No. 3019 Registered No.
(c) City Independence Street No.
(e) Length of residence in city or town where death occurred yrs. mos. ds. (If death occurred in Hospital or Institution, write its name instead of street and number) How long in U.S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

(a) Residence, No. John T. Higginson St. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX m 4. COLOR OR RACE w 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED m (write the word)

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

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

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min. 66 3 29

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. 9. Industry or business in which work was done, as saw mill, bank, etc. 10. Date deceased last worked at this occupation (month and year) 11. Total time (years) spent in this occupation

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

FATHER 13. NAME

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

MOTHER 15. MAIDEN NAME

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

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL

PLACE DATE

19. FUNERAL DIRECTOR (ADDRESS)

20. FILED 19

Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 7-7-39

22. I HEREBY CERTIFY, That I attended deceased from

I last saw h. alive on 19..... Death is said to have occurred on the date stated above, at..... m.

The principal cause of death and related causes of importance were as follows:

Heart Prostration
Pulmonary Hemorrhage
Congestion

Other contributory causes of importance:

Head Stroke

Name of operation 191 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 Russell W. Kerr, M. D.

(Address) 1827 E. 59th

SUPPLEMENTAL

CAUSE OF DEATH IN plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

Form with handwritten entries for Jackson, Independence, John T. Higginson, 66-3-29, 7-7-39, Heart Prostration, Pulmonary Hemorrhage, Congestion, Head Stroke, Russell W. Kerr, M.D., 1827 E. 59th.