

AUG 10 1939

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

Do not use this space.

26181

File No.
Registered No. St. Ward

1. PLACE OF DEATH

County Macon / Registration District No. 532
Township Primary Registration District No. 4318
City Zablatia (No., St., Ward)

2. FULL NAME

James 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 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Married
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Ethel Huffman
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) July 14 - 1869
7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
69 10 3
8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Retired Farmer
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

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Way Co Mo
13. NAME Frank Huffman
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Mo
15. MAIDEN NAME Anna Bledsoe
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Mo

17. INFORMANT Guy T. Huffman
(ADDRESS) Zablatia Mo
18. BURIAL, CREMATION, OR REMOVAL
PLACE Zablatia DATE July 20 1939
19. UNDERTAKER Dr. Christie 475
(ADDRESS) Zablatia
20. FILED July 19 1939 Louise J. Smith
Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) July 17 1939
22. I HEREBY CERTIFY That I attended deceased from July 18 1939 to July 18 1939
I last saw him alive on July 18 1939 Death is said to have occurred on the date stated above, at 10 a.m.
The principal cause of death and related causes of importance were as follows:

Cancer Stomach
46
Other contributory causes of importance:
Abdominal Hernia
Senile Dementia
Name of operation none Date of none
What test confirmed diagnosis? none Was there an autopsy? NO

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? NO
If so, specify H.O. Newton M. D.
(Signed) H.O. Newton M. D.
(Address) Zablatia Mo.

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

RECEIVED

District Health Officer No. 10

District File Number 8-39-1345

Date Filed AUG 4 1933