REC'D SEP 12 1939

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

29609
Do not use this space.

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.

1. PLACE OF DEATH
(a) County Livingston Registration District No. 508
(b) Township Primary Registration District No. 3026 Registered No. 104
(c) City Chillicothe (d) 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 5 yrs. 0 mos. 0 ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME 0007 Thomas S. Huey
(a) Residence, No. 1521 Clay St.
(Usual place of abode, if no street address, write county or city) (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 (write the word): Widowed
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF ~~(OR) WIFE OF~~: Unknown
6. DATE OF BIRTH (MONTH, DAY, AND YEAR): Oct-14-1866
7. AGE: Years 72 Months 9 Days 25 If LESS than 1 day, ...hrs. or ....min.

OCCUPATION
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.: Sawmill
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: 10

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Unknown Illinois

FATHER
13. NAME: Fred Huey
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Unknown Illinois

MOTHER
15. MAIDEN NAME: Unknown
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Unknown Unknown

17. INFORMANT (ADDRESS): Floyd Huey Chillicothe Mo
18. BURIAL, CREMATION, OR REMOVAL PLACE Laredo Mo DATE Aug-10 1939
19. FUNERAL DIRECTOR (NAME) (ADDRESS): F. A. Meinershagen Chillicothe Mo
20. FILED August 10 1939. A. M. Grace MD Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR): Aug-9 1939
22. I HEREBY CERTIFY, That I attended deceased from Aug 2 1939 to Aug 9 1939
I last saw him alive on Aug 9 1939. Death is said to have occurred on the date stated above, at 10 30 A.m.
The principal cause of death and related causes of importance were as follows:

	Date of onset
Chronic Interstitial Nephritis	1935
Other contributory causes of importance: 321	

Name of operation: Date of:
What test confirmed diagnosis? Clinical 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
(Signed) A. Pallin, M. D.
(Address) 943 Chillicothe Mo

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 11
939-1147
SEP 8 1939

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, Elmer Thomas, or by .....

Registered Apprentice No....., working under my personal supervision.

Signed Elmer Thomas

Licensed Embalmer No. 2640

P. O. Address Chillicothe M

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

If this body is not embalmed, above space should be left blank.