

JAN 12 1940

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

43096  
Do not use this space.

1. PLACE OF DEATH  
 (a) County Clark Registration District No. 194  
 (b) Township Wyalonda Primary Registration District No. 4177  
 (c) City Wyalonda (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 yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Josephine Wade Huffman  
 (a) Residence, No. Wyalonda Mo 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 Female 4. COLOR OR RACE Wht 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Widowed

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Nov 18 1860

7. AGE YEARS MONTHS DAYS If LESS than 1 day, .....hrs. or .....min.  
79 0 25

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Housewife  
 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) Clark County Mo  
Indiana

FATHER 13. NAME George Wade 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Indiana

MOTHER 15. MAIDEN NAME Frank 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Indiana

17. INFORMANT (ADDRESS) Mary Lingenselter  
Wyalonda Mo

18. BURIAL, CREMATION, OR REMOVAL PLACE Millport DATE 12/17/1939

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Bailey Used. Co  
Rutledge Mo

20. FILED Dec 19 1939 Bessie Blatter Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 12/13/1939

22. I HEREBY CERTIFY, That I attended deceased from Nov 14, 1939, to Dec 13, 1939.  
 I last saw her alive on Dec 10, 1939. Death is said to have occurred on the date stated above, at 5 a.m.  
 The principal cause of death and related causes of importance were as follows:  
Senile infirmities  
43k  
 Other contributory causes of importance:  
myocarditis with falling compensation  
 Name of operation \_\_\_\_\_ Date of \_\_\_\_\_  
 What test confirmed diagnosis? Phys. Exam 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) Dr. B. F. Hutchinson Mo  
 (Address) Wyalonda, 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.

RECEIVED

District Health Officer No. 10

District File Number 1-40-175

Date Filed JAN 12 1940

---

---

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, or by.....

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

Signed.....

Licensed Embalmer No.....

P. O. Address.....

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

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