

33 1940 796  
Registration District No.

6039 ✓  
Primary Registration District No.

State File No. \_\_\_\_\_  
Registrar's No. 43

1. PLACE OF DEATH:  
(a) County Saline  
(b) City or town Marshall Rural  
(c) Name of hospital or institution:  
Saline County Home 3  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 3 yrs  
(Specify whether  
In this community \_\_\_\_\_  
years, months or days)

3. (a) PRINT FULL NAME Martha Elizabeth Huff 67  
8. (b) If veteran, name war no 8. (c) Social Security No. \_\_\_\_\_  
4. Sex female 5. Color or race white 6. (a) Single, widowed, married, divorced widowed  
6. (b) Name of husband or wife none 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased Sept. 18 1884  
(Month) (Day) (Year)

8. AGE: Years 85 Months 5 Days 13  
If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace Howard County, Mo.  
(City, town, or county) (State or foreign country)

10. Usual occupation at home

11. Industry or business Stephen Pemberton

MOTHER FATHER { 12. Name Stephen Pemberton  
13. Birthplace Kentucky  
14. Maiden name Martha Dougherty  
15. Birthplace Va.  
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Mrs. Beuna Norris  
(b) Address St. Louis, Mo.

17. (a) \_\_\_\_\_ (b) Date thereof 3/3/40  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation Gilliam, Mo.

18. (a) Signature of funeral director Hill Brothers,  
(b) Address Stater, Mo.

19. (a) 3-2-40 (b) Mary Kent  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:  
(a) State Mo. (b) County Saline  
(c) City or town Marshall  
(If outside city or town limits, write "RURAL")  
(d) Street No. \_\_\_\_\_  
(If rural, give location)  
(e) If foreign born, how long in U. S. A. \_\_\_\_\_ years

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month Mch. day 1st  
year 1940 hour 5 minute \_\_\_\_\_ P. M.  
21. I hereby certify that I attended the deceased from Feb 28  
1940 to 3/1 1940;  
that I last saw her alive on Feb 28 1940;  
and that death occurred on the date and hour stated above.  
Immediate cause of death Suppurative pneumonia Duration 1 wk  
Due to Basinella free ?  
Due to \_\_\_\_\_  
Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_  
Major findings: Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_  
PHYSICIAN \_\_\_\_\_  
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:  
(a) Accident, suicide, or homicide (specify) \_\_\_\_\_  
(b) Date of occurrence \_\_\_\_\_  
(c) Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)  
(d) Did injury occur in or about home, on farm, in industrial place, in public place?  
While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury \_\_\_\_\_  
23. Signature [Signature] (M. D. or other) \_\_\_\_\_  
Address Marshall Mo. Date signed 3/3/40

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.

502

RECEIVED  
District Health Officer No. 8,  
Health File Number  
Date Filed 4-9-40

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~~ by Edgar Moore, Registered Apprentice No. 230 working under my personal supervision.

Signed A. C. Hill  
Licensed Embalmer No. 3090  
P. O. Address Slater, Mo.

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.)

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

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 12534  
Registrar's No. 43

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

Registration District No. 796

Primary Registration District No. 6039

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:  
(a) County Saline  
(b) City or town Marshall  
(c) Name of hospital or institution:  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether)  
In this community \_\_\_\_\_ (Specify whether)  
years, months or days

2. USUAL RESIDENCE OF DECEASED:  
(a) State \_\_\_\_\_ (b) County \_\_\_\_\_  
(c) City or town \_\_\_\_\_ (If outside city or town limits write "RURAL")  
(d) Street No. \_\_\_\_\_ (If rural, give location)  
(e) If foreign born, how long in U. S. A.? \_\_\_\_\_ years.

3. (a) PRINT FULL NAME Martha Elizabeth Huff  
(b) If veteran, name war \_\_\_\_\_ (c) Social Security No. \_\_\_\_\_  
4. Sex 7 5. Color or race W 6. (a) Single, widowed, married, divorced wid  
6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband, or wife, if alive \_\_\_\_\_ years  
7. Birth date of deceased \_\_\_\_\_ (Month) (Day) (Year)

4. MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month July day 1 year 1960 hour \_\_\_\_\_ minute \_\_\_\_\_ M.  
21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_; that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_ and that death occurred on the date and hour stated above.

8. AGE: Years Months Days If less than one day  
85 5 13 \_\_\_\_\_ min.

Immediate cause of death Hypostatic pneumonia  
Due to Carcinoma of face  
Due to N.M.D.  
Other conditions \_\_\_\_\_ (Include pregnancy within 3 months of death)

9. Birthplace \_\_\_\_\_ (City, town, or county) (State or foreign country)  
10. Usual occupation \_\_\_\_\_  
11. Industry or business \_\_\_\_\_  
12. Name \_\_\_\_\_  
13. Birthplace \_\_\_\_\_ (City, town, or county) (State or foreign country)  
14. Maiden name \_\_\_\_\_  
15. Birthplace \_\_\_\_\_ (City, town, or county) (State or foreign country)

Major findings: Of operations 57  
Of autopsy \_\_\_\_\_  
PHYSICIAN \_\_\_\_\_ Underline the cause to which death should be charged statistically.

16. (a) Informant \_\_\_\_\_ (b) Address \_\_\_\_\_  
17. (a) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_ (Month) (Day) (Year)  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation \_\_\_\_\_  
18. (a) Signature of funeral director \_\_\_\_\_ (b) Address \_\_\_\_\_  
19. (a) \_\_\_\_\_ (b) \_\_\_\_\_ (Date received local registrar) (Registrar's signature)

22. If death was due to external causes, fill in the following:  
(a) Accident, suicide, or homicide (specify) \_\_\_\_\_  
(b) Date of occurrence \_\_\_\_\_  
(c) Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)  
(d) Did injury occur in or about home, on farm, in industrial place, in public place? \_\_\_\_\_  
While at work \_\_\_\_\_ (Specify type of place) (c) Means of injury \_\_\_\_\_  
23. Signature R.C. Hargreaves (M. D. or other)  
Address Marshall Date July 1, 1960

SUPPLEMENTARY

1940

S-12554