

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **33687**

Registrar's No. **8384**

Registration District No. **791**

Primary Registration District No. **1003**

1. PLACE OF DEATH:

(a) County _____
(b) City or town **St. Louis, Missouri**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
St. Louis City Hospital #1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **2 Mos. 5 Days**
(Specify whether
In this community _____
years, months or days)

3. (a) PRINT FULL NAME **Claude Huffine**

3. (b) If veteran, name war _____ 3. (c) Social Security No. **None**

4. Sex **Male** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **Divorced**

6. (b) Name of husband or wife **Not known** 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased **August 1879**
(Month) (Day) (Year)

8. AGE: Years **61** Months **2** Days **X** If less than one day hr. _____ min.

9. Birthplace **Kentucky**
(City, town, or county) (State or foreign country)

10. Usual occupation **Retired salesman**

11. Industry or business **Automobile**

12. Name **Joseph Huffine**

13. Birthplace **Not known**
(City, town, or county) (State or foreign country)

14. Maiden name **Elizabeth Meadows**

15. Birthplace **Not known**
(City, town, or county) (State or foreign country)

16. (a) Informant **J. Schuler**

(b) Address **2837 N. Grand**

17. (a) **Burial** (b) Date thereof **10/9/40**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Memorial Park Cem.**

18. (a) Signature of funeral director **Charles Brown**

(b) Address **4911 Washington Bl.**

19. (a) **OCT 9 1940** (b) **J. Schuler**
(Date received local Registrar) (Registrar's Signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo** (b) County _____
(c) City or town **St. Louis**
(If outside city or town limits, write "RURAL")
(d) Street No. **5800 Arsenal (City Infirmary)**
(If rural, give location)
(e) If foreign born, how long in U. S. A. ? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **October** day **8**,
year **1940** hour **2:30** minute **A. M.**

21. I hereby certify that I attended the deceased from **August 3**, 19**40** to **October 8**, 19**40**;
that I last saw him alive on **October 8**, 19**40**;
and that death occurred on the date and hour stated above.

Immediate cause of death
Thromboembolism (Pulmonary disease)
Due to **Renal Calculi**

Due to _____
Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations **See above**
Of autopsy **See above**

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 **J. C. T. ...** (M. D. or other) **10/8/40**
Address **1515 Lafayette Ave.** Date signed

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

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. 3793

P. O. Address St Louis 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.