

Registration District No. **624**

Primary Registration District No. **5828**

Registrar's No. \_\_\_\_\_

DEC 21 1940

1. PLACE OF DEATH:

(a) County Madaway  
 (b) City or town Pranell  
 (If outside city or town limits, write "RURAL" and name of township)  
 (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 12 years  
 years, months or days \_\_\_\_\_

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Madaway  
 (c) City or town Pranell  
 (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 Aug day 2  
 year 1940 hour 14 minute 50 A.M.  
 21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_.

3. (a) PRINT FULL NAME MAJOR ANDERSON HUFF

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced married

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive 75 years

7. Birth date of deceased March 2 1849  
 (Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>91</u>	<u>5</u>	<u>0</u>	hr. _____ min.

9. Birthplace De Kalb, Co. Mo.  
 (City, town, or county) (State or foreign country)

10. Usual occupation farmer

11. Industry or business \_\_\_\_\_

12. Name William Huff  
 13. Birthplace Uniontown, Mo.  
 (City, town, or county) (State or foreign country)

14. Maiden name Ellen Glenn  
 15. Birthplace Henry, Mo.  
 (City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Fred Allen  
 (b) Address Grant City, Mo.

17. (a) Interment (b) Date thereof 8, 4, 1940  
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Madaway Cem.  
 18. (a) Signature of funeral director A. C. Dunfee  
 (b) Address Grant City, Mo.

19. (a) 12-2-1940 (b) Wallace Kennedy  
 (Date received local registrar) (Registrar's signature)

that I last saw him alive on \_\_\_\_\_, 19\_\_\_\_, and that death occurred on the date and hour stated above.

Immediate cause of death arterial sclerosis Duration \_\_\_\_\_

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions (include pregnancy within 3 months of death) \_\_\_\_\_

Major findings: Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

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? \_\_\_\_\_

551 (Specify type of place) While at work? \_\_\_\_\_ (e) Means of injury \_\_\_\_\_

23. Signature Fred Mull (M. D. or other) \_\_\_\_\_

Address Grant City Mo Date signed 8-4-40

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

MOTHER FATHER

PHYSICIAN  
Underline the cause to which death should be charged statistically.

**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 Arch C. Duplee  
Licensed Embalmer No. 3252  
P. O. Address Grant City, Mo.

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

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