

S. No. 2
4-13-40
5-17-39
I X2315

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 7530

MAR 19 1945 30
Registration District No. 2

Primary Registration District No. 5708

Registrar's No.

1. PLACE OF DEATH:
 (a) County Macon
 (b) City or town Rural - Eastley Mo.
(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 _____
years, months or days

2. USUAL RESIDENCE OF DECEASED:
 (a) State Missouri (b) County Macon Co
 (c) City or town Rural
(If outside city or town limits, write "RURAL")
 (d) Street No. Southwest of So. Coffard
(If rural, give location)
 (e) If foreign born, how long in U. S. A. _____ years.

3. (a) PRINT FULL NAME DELLA R. HUFFMAN
 3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month Feb day 3
 year 1941 hour 4-10 minute _____ P.M.
 21. I hereby certify that I attended the deceased from Jan 26
 1941, to Feb 3, 1941;
 that I last saw her alive on Feb 3, 1941;
 and that death occurred on the date and hour stated above.

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Married
 6. (b) Name of husband or wife Lewis Huffman 6. (c) Age of husband or wife if alive 71 years
 7. Birth date of deceased Oct 10-1879
(Month) (Day) (Year)

Immediate cause of death Bronchial Pneumonia
Influenza
 Due to _____
 Due to _____
 Other conditions Asthma for several years
(Include pregnancy within 3 months of death)

8. AGE: Years 61 Months 3 Days 23
 If less than one day _____ hr. _____ min.

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

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

10. Usual occupation Housewife

11. Industry or business _____

12. Name John Still

13. Birthplace _____
(City, town, or county) (State or foreign country)

14. Maiden name Mary Ann Hubbard

15. Birthplace Mo.
(City, town, or county) (State or foreign country)

16. (a) Informant Lewis Huffman

(b) Address Elmer, Mo. R.R.

17. (a) Burial (b) Date thereof Feb 5 1941
(Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation Belle

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?
472
(Specify type of place) (e) Means of injury _____

23. Signature Harold DeLoach (M. D. or other) DO
 Address Elmer, Mo. Date signed Feb 7/41

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

MOTHER FATHER

RECEIVED

District Health Officer No. 10

District File Number 3-41-622

Date Filed MAR 14 1941

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

W. H. McCallum

Licensed Embalmer No. 2052

P. O. Address South Effo.

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, fact should be so stated above.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 7530

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. 232

Primary Registration District No. 5708

Registrar's No.

WRITE PLAINLY--USE UNFADING BLACK INK--MAKE A PERMANENT RECORD
ROBERTA MOORE

1. PLACE OF DEATH:

(a) County Mason
(b) City or town Easley, P.
(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 _____ years, months or days

3. (a) PRINT FULL NAME Della R. Huffman

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

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

6. (b) Name of husband or wife _____ 6. (c) Age of husband, or wife, if alive _____ years

7. Birth date of deceased Oct 10 1879
(Month) (Day) (Year)

8. AGE: Years 64 Months 23 Days 23 If less than one day _____ min.

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 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)

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof: _____ (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) March 10 1944 (b) Mrs Lloyd Baker
(Date received local registrar) (Registrar's signature)

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.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb day 3
year 1944 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.

Immediate cause of death _____

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? _____

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature Harold D. Lehr (M. D. or other)

Address Elmer, Mo Date signed _____

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

SUPPLEMENTARY

