

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. **36988**  
Registrar's No. **46**

FILED OCT 28 1943 378

Primary Registration District No. **4552**

1. PLACE OF DEATH:

(a) County **Wright**  
(b) City or town **Mountain Grove**  
(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 **1**  
In this community **Life**  
years, months or days (Specify whether)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Wright 114**  
(c) City or town **Mtn Grove Mo.**  
(If outside city or town limits, write "RURAL")  
(d) Street No. (If rural, give location)  
(e) Citizen of foreign country? **NO** (Yes or No)  
If yes, name country **0**

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **10** day **4**  
year **1943** hour **11** minute **P.** M.  
21. I hereby certify that I attended the deceased from **10/4** 19**43** to **viewed the body**  
that I last saw him **alive on** 19**43**  
and that death occurred on the date and hour stated above.

Immediate cause of death **Heart attack**  
Duration

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

Major findings:  
Of operations  
Of autopsy  
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 **R.A. Ryan** (M. D. or other)  
Address **Mtn Grove Mo** Date signed **10/4-43**

3. (a) PRINT FULL NAME **Lucy Ann Huff**

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

4. Sex **female** 5. Color or race **white** 6. (a) Single, widowed, married, divorced **married**  
6. (b) Name of husband or wife **J.C. Huff** 6. (c) Age of husband or wife if alive **79** years  
7. Birth date of deceased **August 31 1864**  
(Month) (Day) (Year)

8. AGE: Years **79** Months **1** Days **4** If less than one day hr. min.

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

10. Usual occupation **House wife**

11. Industry or business

12. Name **Kennelium Murphy**  
13. Birthplace **Marys Co Mo**  
(City, town, or county) (State or foreign country)  
14. Maiden name **Elizabeth Woods**  
15. Birthplace **Marys Co. Mo**  
(City, town, or county) (State or foreign country)

16. (a) Informant **Jama C. Huff**  
(b) Address **Mountain Grove Mo**  
17. (a) **Burial** (b) Date thereof **10/9/43**  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation **Hill Crest Cemetery**

18. (a) Signature of funeral director **George Staff**  
(b) Address **Mtn. Grove Mo**  
19. (a) **10/7/43** (b) **AmLawer**  
(Date received local registrar) (Registrar's signature)

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

MOTHER FATHER

1332

(Licensed Embalmer's Statement on Reverse Side)

NOV 9 1950

RECEIVED  
District Health Officer No. 6,  
District File Number 1043-1171  
Date Filed OCT 25 1943

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 *George Stoff*  
Licensed Embalmer No. 3161  
P. O. Address *Mt. Zion, N.C.*

**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.**

Registration District No. 378 Primary Registration District No. 450-2

1. PLACE OF DEATH:  
(a) County Wright  
(b) City or town Mountain Grove  
(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 Lucy Ann Key  
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

7. Birth date of deceased Aug 3  
(Month) (Day) (Year)

8. AGE: Years 29 Months 1 Days 1 Unless than one day min.

9. Birthplace Mo.  
(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)

16. (a) Informant

(b) Address

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

(c) Place: burial or cremation

18. (a) Signature of funeral director

(b) Address

19. (a) (Date received local registrar) (b) (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) Citizen of foreign country? (Yes or No)  
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct year 1943 hour 10 minute 4 M.

21. I hereby certify that I attended the deceased from 1943 to 1943 that I last saw him alive on 10/3/43 and that death occurred on the date and hour stated above.

Immediate cause of death Heart attack Duration  
Chronic myocarditis?

Due to

Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations 93d

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) Means of injury

23. Signature R.A. Pilon (M. D. or other)

Address Mountain Grove Date signed 10/31-43

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

SUPPLEMENTARY

MOTHER FATHER

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

36069