DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED FEB 14 1944

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 2954

Registration District No. 1 9 2 — Primary Registration District No. 3021 — Registrar's No. 189

1. PLACE OF DEATH:

(a) County GRUNDY

(b) City or town TRENTON
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: 712 W. 12" /
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution ____ (Specify whether years, months or days)

In this community LIFE

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County GRUNDY 40

(c) City or town TRENTON 9
(If outside city or town limits, write "RURAL")

(d) Street No. 712 W. 12"
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country ____

3. (a) PRINT FULL NAME FANNIE FOSTER HUFFSTUTTER

3. (b) If veteran, name war —

3. (c) Social Security No. —

4. Sex FE.

5. Color or race W.

6. (a) Single, widowed, married, divorced SINGLE

6. (b) Name of husband or wife —

6. (c) Age of husband or wife if alive — years

7. Birth date of deceased DEC. (Month) 20 (Day) 1908 (Year)

8. AGE: Years	Months	Days	If less than one day
35	0	10	hr. ____ min.

9. Birthplace K.C. (City, town, or county) MO (State or foreign country) 0

10. Usual occupation HOUSE WORK

11. Industry or business Home

FATHER
12. Name GEO. FOSTER
13. Birthplace DO NOT KNOW (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name ANNA REED
15. Birthplace CAMERON (City, town, or county) MO (State or foreign country) 0

16. (a) Informant LOUIS HUFFSTUTTER
(b) Address TRENTON MO.

17. (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 1/2/44 (Month) (Day) (Year)
(c) Place: burial or cremation MAPLE GROVE

18. (a) Signature of funeral director GIBSON FUN. HOME
(b) Address TRENTON MO.

19. (a) 1-3-44 (Date received local registrar) (b) L. D. Roberts (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month DEC day 30 year 43 hour 9 minute 10 M.

21. I hereby certify that I attended the deceased from DEC 30, 1943 to ____ 19____; that I last saw him alive on DEC 30 1943 and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Retro peritoneal hemorrhage	2 days
Due to ruptured blood vessel	
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? ____ (Specify type of place)
While at work? ____ (e) Means of injury ____

23. Signature [illegible] (M. D. or other)
Address Trenton MO Date signed 1/3/45

(Licensed Embalmer's Statement on Reverse Side)

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 C. M. Coines

Licensed Embalmer No. 3453

P. O. Address Trenton M

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, fact should be so stated above.

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 7-6

Registration District No. ____ Primary Registration District No. ____ Registrar's No. ____

1. PLACE OF DEATH:
(a) County: Brandy
(b) City or town: Fresburg
(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 years, months or days) In this community ____

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 ____

3. (a) PRINT FULL NAME: Janice F. Huffstutter
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: S
6. (b) Name of husband or wife ____
6. (c) Age of husband or wife if alive ____ years
7. Birth date of deceased: Dec. (Month) 20 (Day) 1943 (Year)
8. AGE: Years 35 Months 0 Days ____ If less than one day ____ hr. ____ min.
9. Birthplace: Mo. (City, town, or county) (State or foreign country)
10. Usual occupation ____
11. Industry or business ____
FATHER 12. Name ____
FATHER 13. Birthplace ____ (City, town, or county) (State or foreign country)
MOTHER 14. Maiden name ____
MOTHER 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)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec. day ____ year 1943 hour ____ minute ____ M.
21. I hereby certify that I attended the deceased from ____, 19____, to ____, 19____; that I last saw h____ alive on ____, 19____; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Peritoneal Hemorrhage	
Due to: Ruptured Blood Vessel	
Due to: I did not see the pt. until about 1 hr before death	
Other conditions (Include pregnancy within 3 months of death):	
Major findings of operations: Do not Know	
Of autopsy: PK deferring Cause of Death	

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? ____ (Specify type of place)
While at work? ____ (e) Means of injury ____
23. Signature ____ (M. D. or other) ____
Address ____ Date signed ____

SUPPLEMENTARY

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