No. 2
9-4-41
5-17-39
X29484

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED FEB 9 1944

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 4793

Registration District No. 269 Primary Registration District No. 6252 Registrar's No. 3

1. PLACE OF DEATH:

(a) County Wayne
(b) City or town Leeper Rural, Millspring twp.
(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 (Specify whether
In this community 1 YR years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Wayne 111
(c) City or town Leeper Rural 0
(If outside city or town limits, write "RURAL") 0
(d) Street No. 6 miles west of Leeper
(If rural, give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country NO 0

3. (a) PRINT FULL NAME Rosie B. Huff

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

4. Sex Female 1 5. Color or race White 6. (a) Single, widowed, married, divorced Single 0
6. (b) Name of husband or wife ✓ 6. (c) Age of husband or wife if alive ✓ years
7. Birth date of deceased Apr (Month) 8 (Day) 1889 (Year)

8. AGE: Years	Months	Days	If less than one day
54 ~~52~~	8	18	✓ hr. ✓ min.

9. Birthplace Iron County (City, town, or county) 0 Missouri (State or foreign country)
10. Usual occupation Housework
11. Industry or business Home

FATHER
12. Name Hampton Huff 0
13. Birthplace Iron County (City, town, or county) Missouri (State or foreign country)

MOTHER
14. Maiden name Susie Campbell 0
15. Birthplace Shannon Co. (City, town, or county) Missouri (State or foreign country)

16. (a) Informant Sophia Edna Ellington
(b) Address Leeper, Missouri
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 12 (Month) 28 (Day) 1943 (Year)
(c) Place: burial or cremation Clay Cem.
18. (a) Signature of funeral director N. W. Gish
(b) Address Piedmont, Missouri
19. (a) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 26
year 1943 hour 3 minute 30 P.M.
21. I hereby certify that I attended the deceased from Dec 15, 1943 to Dec 26, 1943
that I last saw her alive on Dec 20, 1943
and that death occurred on the date and hour stated above.

Immediate cause of death Influenza and Pneumonia

Due to

Due to

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

Duration

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 T. C. Giles (M. D. ~~or other~~)
Address Piedmont Mo Date signed 1-5-1944

1103 (Licensed Embalmer's Statement on Reverse Side)

FEB 9 1944

RECEIVED

District Health Officer No. 4

District File Number 244-3273

Date Filed 2-5-44

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 Norman W. Fish

Licensed Embalmer No. 3387

P. O. Address Piedmont, Missou

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

If this body is not embalmed, fact should be so stated above.

S. No. 2B
OM—S-43
I X36920

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. Feb.

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

1. PLACE OF DEATH:

(a) County Wayne

(b) City or town Rural
(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 1 yr.

2. USUAL RESIDENCE OF DEACESED:

(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 Rose B. Huff

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 W

6. (b) Name of husband or wife .....

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

7. Birth date of deceased April (Month) 8 (Day) 1889 (Year)

8. AGE: Years 54 | Months 8 | 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 .....
13. Birthplace ..... (City, town, or county) ..... (State or foreign country)

MOTHER
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) Jan. 18, 1944 (Date received local registrar) (b) Mrs. Lottie Manns (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan. day 26 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.

Immediate cause of death	Duration
Due to	
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 ..... (M. D. or other) .....
Address ..... Date signed .....

SUPPLEMENTARY

4793

MAY 2 1944