S. No. 2
OM—2-43
. 5-17-39
I X35697

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

6133

State File No.

FILED MAR 6 1944

Registration District No. 449

Primary Registration District No. 1002

Registrar's No. 5728

1. PLACE OF DEATH:

(a) County Jackson

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

(c) Name of hospital or institution: 1414 Harrison
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution ..... (Specify whether
In this community 20 yrs
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson 48

(c) City or town Kansas City 3
(If outside city or town limits, write "RURAL") 8

(d) Street No. 1414 Harrison
(If rural, give location)

(e) Citizen of foreign country? ..... (Yes or No) 0

If yes, name country .....

3. (a) PRINT FULL NAME James Huffman

3. (b) If veteran, name war no

3. (c) Social Security No. ?

4. Sex Male

5. Color or race White

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 Mar 14 1900
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
43	5	28	..... hr. ..... min.

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

10. Usual occupation Cook

11. Industry or business Pedler of Razor blade

FATHER
12. Name Huffman
13. Birthplace no Record 9
(City, town, or county) (State or foreign country)

MOTHER
14. Maiden name no Record
15. Birthplace no Record 9
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs Marie Duffy
(b) Address 1414 Harrison

17. (a) Burial (b) Date thereof Sept-15-1943
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Leeds

18. (a) Signature of funeral director Wm A. Johnson
(b) Address City Mortician

19. (a) 9-15-43 (b) T. E. Brown
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 12
year 1943 hour 2:00 minute 10 a M.

21. I hereby certify that I attended the deceased from June 12, 1943 to Sept 12, 1943
that I last saw him alive on Aug 3rd, 1943
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Hemorrhage (pulmonary)	
Due to Tuberculosis	
Due to	
Other conditions Luetic (Include pregnancy within 3 months of death)	

Major findings:
Of operations .....
Of autopsy .....

309

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 [signature] (M. D. or other) 2 Do

Address 709-10 Bruker Bldg Date signed 9/13/43

(Licensed Embalmer's Statement on Reverse Side)

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.....

Licensed Embalmer No.....

P. O. Address.....

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.