

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **22177**

FILED JUL 11 1944
Registration District No. **5867**

Primary Registration District No. **5867**

Registrar's No. **1**

1. PLACE OF DEATH:
 (a) County Oregon
 (b) City or town Thayer (Rural) Thayer 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) 1
 (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 Oregon **75**
 (c) City or town Thayer (Rural)
 (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 _____ **D**

3. (a) PRINT FULL NAME Ida Sophia 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 Lum Huff
6. (c) Age of husband or wife if alive 61 years
7. Birth date of deceased August 30 1884
 (Month) (Day) (Year)

8. AGE: Years 59 Months 8 Days 18
 If less than one day
 hr. _____ min. _____

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

10. Usual occupation Housewife

11. Industry or business _____

MOTHER FATHER

12. Name DeWitt Irvin
13. Birthplace Fulton County Arkansas
 (City, town, or county) (State or foreign country)
14. Maiden name Cynthia Ellis
15. Birthplace Fulton County Arkansas
 (City, town, or county) (State or foreign country)

16. (a) Informant Lum Huff
(b) Address Thayer, Mo.

17. (a) Burial (Burial, cremation, or removal) **(b) Date thereof** 5/20/44
 (Month) (Day) (Year)
(c) Place: burial or cremation Shiloh Cem.

18. (a) Signature of funeral director Reg. Darr
(b) Address Thayer, Mo.

19. (a) 6-15-44 (Date received local registrar) **(b) Joe D. Williams** (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 18
 year 1944 hour 5 minute 05 P. M.
21. I hereby certify that I attended the deceased from May 2
1944 to May 18 1944
 that I last saw him alive on May 17 1944
 and that death occurred on the date and hour stated above

Immediate cause of death Cerebral Hemorrhage
 Due to Hypertensive Heart Disease
 Due to _____

Duration 7 days

Other conditions (Include pregnancy within 5 months of death) 93d
 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?

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

23. Signature D. W. Cooper (M. D. or other) M. D.
Address Thayer, Mo. Date signed 6-2-44

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

7500

1112

Cost per.

RECEIVED

District Health Officer No. 5.

District File Number 744-807

Date Filed 7-10-44

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.....

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.