

FILED NOV 22 1944

Registration District No. **47**

Primary Registration District No. **4068-5171**

Registrar's No. **344**

1. PLACE OF DEATH:

(a) County **CALLAWAY**

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

(c) Name of hospital or institution: **RURAL St. Louis**  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution **1** (Specify whether years, months or days)

In this community **1** (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo** (b) County **Callaway**

(c) City or town **Rural** (If outside city or town limits, write "RURAL")

(d) Street No. **R#1 Mohane** (If rural, give location)

(e) Citizen of foreign country? (Yes or No) **1**  
If yes, name country

3. (a) PRINT FULL NAME **Thressi Elizabeth HUFFMAN**

3. (b) If veteran, name war **No**

3. (c) Social Security No. **NO**

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **10** day **14**  
year **1944** hour **9** minute **30 P.M.**

4. Sex **FEMALE**

5. Color or race **White**

6. (a) Single, widowed, married, divorced **MARRIED**

6. (b) Name of husband or wife **WILLIAM B.**

6. (c) Age of husband or wife if alive **79** years

7. Birth date of deceased: **July 15 1873**  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from **9-12 1944** to **10-15 1944**

that I last saw her alive on **10-14 1944** and that death occurred on the date and hour stated above.

8. AGE:

Years	Months	Days	If less than one day
<b>71</b>	<b>2</b>	<b>29</b>	hr. min.

Immediate cause of death: **Mitral Heart Insufficiency 10 years & Aneurysm Coelitis**

Due to

9. Birthplace **Boone Co. MO.**  
(City, town, or county) (State or foreign country)

Other conditions: **Active Hypertension**  
(Include pregnancy within 3 months of death)

Due to

10. Usual occupation **Housewife**

Major findings: **92%**

Of operations

Of autopsy

PHYSICIAN

Underline the cause to which death should be charged statistically.

MOTHER FATHER

11. Industry or business

12. Name **Noah BOOPER**

13. Birthplace **UNKNOWN**  
(City, town, or county) (State or foreign country)

14. Maiden name

15. Birthplace **11**  
(City, town, or county) (State or foreign country)

16. (a) Informant **ALBERT HUFFMAN**

(b) Address **NEW FRANKLIN, MO**

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?

17. (a) **BURIAL** (Burial, cremation, or removal)

(b) Date thereof **OCT. 18, 1944**  
(Month) (Day) (Year)

(c) Place: burial or cremation **MOHANE**

While at work? (Specify type of place)

(e) Means of injury

18. (a) Signature of funeral director **Elen G. Morgan**

(b) Address **712 Cant St. Fulton, Mo**

19. (a) **OCT 16 1944** (Date received local registrar)

(b) **Joan M. Muehlhoff** (Registrar's signature)

23. Signature **W. O. Payne** (M. D. or other)

Address **R. B. Fulton** Date signed **10-16 1944**

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

4  
0  
0

RECEIVED

District Health Officer No. 9

District File Number.....

Date Filed 11-17-44

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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 Wm. J. Maupin.....

Licensed Embalmer No. 2725.....

P. O. Address Fulton, Mo......

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.