

Registration District No. 344

Primary Registration District No. 6166

1. PLACE OF DEATH:

(a) County. Stone  
(b) City or town. Rural *(Rural sum)*  
(c) Name of hospital or institution:  
R.F.D.  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution.....  
In this community.....  
years, months or days) (Specify whether

2. USUAL RESIDENCE OF DECEASED:

(a) State. Missouri (b) County. Stone 104  
(c) City or town. Rural 0  
(d) Street No. R.F.D. (If rural, give location)  
(e) Citizen of foreign country? No (Yes or No)  
If yes, name country. 0

3. (a) PRINT FULL NAME Otis Freeman Huffhines

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

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced. Married

6. (b) Name of husband or wife. Captola Huffhines 6. (c) Age of husband or wife if alive. 53 years

7. Birth date of deceased. Feb. 3  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
61 hr. min.

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

10. Usual occupation Farmer

11. Industry or business Retired

MOTHER FATHER { 12. Name Robert Huffhines  
13. Birthplace ? Texas  
(City, town, or county) (State or foreign country)  
14. Maiden name Maranda Neill  
15. Birthplace ? Tenn.  
(City, town, or county) (State or foreign country)

16. (a) Informant S.P. Huffhines

(b) Address Crane Mo.

17. (a) Burial (b) Date thereof. 8/13/44  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Crane Mo

18. (a) Signature of funeral director J.F. King

(b) Address Aurora Mo.

19. (a) 8/13/44 (b) Shige madstone  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 10  
year 1944 hour 10 minute 45 P. A. M.

21. I hereby certify that I attended the deceased from Jan - 10 -  
1943 to Aug 10 - 1944  
that I last saw h. im alive on Aug - 9 - 1944  
and that death occurred on the date and hour stated above.

Immediate cause of death Diabetes mellitus Duration 10 yrs.

Due to.....  
Due to 61  
Other conditions. (Include pregnancy within 3 months of death)

Major findings: None  
Of operations.....  
Of autopsy None  
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?.....  
(d) Did injury occur in or about home, on farm, in industrial place, in public place?  
While at work? Yes (Specify type of place) (e) Means of injury.....  
23. Signature H. P. Kerr (M. D. or other) 0  
Address Crane Mo. Date signed 8-13-44

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

0400

RECEIVED

District Health Officer No. 6

District File Number 145-118

Date Filed JAN 22 1945

MAR 23 1945

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 *Herman Surridge*

Licensed Embalmer No. 3072

P. O. Address. Aurora, Ill.

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.