

FILED MAR 12 1945

Registration District No. _____ Primary Registration District No. **3000**

1. PLACE OF DEATH:

(a) County **Adair**

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

(c) Name of hospital or institution: **1224 N. Franklin**
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____ (Specify whether)

In this community **ENTIRE LIFE** (years, months or days)

3. (a) PRINT FULL NAME **Edward Mc Huffee**

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

3. (c) Social Security No.

4. Sex **M.** 5. Color or race **W**

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

6. (b) Name of husband or wife **Josie Mc Huffee**

6. (c) Age of husband or wife if alive **60** years

7. Birth date of deceased **Nov 26 1873**
(Month) (Day) (Year)

8. AGE: Years **71** Months **7** Days **9** If less than one day _____ hr. _____ min.

9. Birthplace **MACON County Mo ()**
(City, town, or county) (State or foreign country)

10. Usual occupation **Railroad**

11. Industry or business **Section Crew**

12. Name **FRANK Mc Huffee**

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

14. Maiden name **Lucy Garvin**

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

16. (a) Informant **Mrs. Josie Mc Huffee**

(b) Address **1224 N. Franklin, Wicksville**

17. (a) **BURIAL** (Burial, cremation, or removal) (b) Date thereof **2-8-45**
(Month) (Day) (Year)

(c) Place: burial or cremation **LA PLATA Mo**

18. (a) Signature of funeral director **E. E. Hopper**

(b) Address **Clarence Mo**

19. (a) **2-19-45** (Date received local registrar) (b) **Mrs. D. Wagoner** (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

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

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

(d) Street No. **1224 N Franklin**
(If rural, give location)

(e) Citizen of foreign country? **No** (Yes or No)

If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Feb** day **5** year **45** hour **8:00** minute **a. m.**

21. I hereby certify that I attended the deceased from **Oct: 1944 to Feb. 3 1945**
that I last saw him alive on **Feb. 3 1945**
and that death occurred on the date and hour stated above.

Immediate cause of death **Cerebral Hemorrhage**

Due to **apoplexy**

Other conditions (Include pregnancy within 3 months of death) _____

Major findings: Of operations **J. J. H.**

Of autopsy **J. J. H.**

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 industrial place, in public place? _____

While at work? _____ (Specify type of place)

(e) Means of injury **MI**

23. Signature **R. P. Stibler** (M. D. or other **MD**)

Address **Wicksville mo** Date signed **2-8-45**

Duration _____

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

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

MOTHER FATHER

1049

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED

Embalmer No. 10
District File No. 10453-45-423
Date Filed MAR 8 1940

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..... *Louis E. Hopper*
Licensed Embalmer No. *7261*
P. O. Address..... *Clarence, W. Va.*

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.