DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 9554

FILED MAR 16 1945

Registration District No. 9

Primary Registration District No. 5375

Registrar's No. 20

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

1. PLACE OF DEATH:

(a) County De Kalb

(b) City or town Santa Rosa Davies Tr.
(If outside city or town limits, write "RURAL" and name of township)

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

(d) Length of stay: In hospital or institution ___ (Specify whether years, months or days)
In this community entire life

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County De Kalb

(c) City or town Santa Rosa
(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

3. (a) PRINT FULL NAME Lillie Mae 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~~ Joe Huff

6. (c) Age of husband or wife if alive 55 years

7. Birth date of deceased Jan (Month) 22 (Day) 1887 (Year)

8. AGE: Years	Months	Days	If less than one day
58	0	19	___ hr. ___ min.

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

10. Usual occupation

11. Industry or business Housewife

FATHER
12. Name Charley Uthe
13. Birthplace not known (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name not known
15. Birthplace ✓ (City, town, or county) (State or foreign country)

16. (a) Informant Joe Huff
(b) Address Santa Rosa Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 12-45 (Month) (Day) (Year)
(c) Place: burial ~~or cremation~~ Alta Vista Cemetry

18. (a) Signature of funeral director G S Gromer
(b) Address Pattonsburg Mo.

19. (a) 2-13-1945 (Date received local registrar) (b) John Clark (Registrar's signature)

MEDICAL CERTIFICATION

20. **DATE OF DEATH:** Month Feb day 11 year 1945 hour 2 minute A M.

21. I hereby certify that I attended the deceased from June, 1943, to Feb. 11, 1945; that I last saw her alive on Feb. 10, 19__; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death	
Due to Hypertension with Cerebral Sclerosis	
Due to Terminal Encephalitis	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations	
Of autopsy	

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

PHYSICIAN

Underline the [illegible] to which [illegible] 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 John Warner (M. D. ~~or other~~)

Address Pattonsburg Date signed 2/12/45

15-78

(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 G S Gromer

Licensed Embalmer No. 2854

P. O. Address Pattonsburg 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.