

FILED SEP 12 1945

Registration District No.

Primary Registration District No. 6041

Registrar's No. 1278

1. PLACE OF DEATH:

(a) County Ripley  
(b) City or town Abbeville, Mo. R.F. Thomas  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: 1 May  
(If not in hospital or institution, write street number or location)  
(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 Ripley  
(c) City or town Naylor, Mo. R.F.  
(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

Olemmie Huffstutler

3. (b) If veteran, name war \_\_\_\_\_

3. (c) Social Security No. \_\_\_\_\_

4. Female 5. Color or race White 6. (a) Single, widowed, married, divorced married  
6. (b) Name of husband or wife Tom Huffstutler 6. (c) Age of husband or wife if alive 65 years  
7. Birth date of deceased Dec. 25 1878  
(Month) (Day) (Year)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 12 year 1945 hour 7 minute 30 A.M.  
21. I hereby certify that I attended the deceased from Aug. 4 1945 to Aug. 9 1945  
that I last saw her alive on Aug. 9 1945  
and that death occurred on the date and hour stated above.

Immediate cause of death

Coronary stenosis

Duration

?

8. AGE: Years 66 Months 7 Days 17 If less than one day hr. min.

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

10. Usual occupation Housewife

11. Industry or business \_\_\_\_\_

12. Name Marion Howell

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

14. Maiden name unknown

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

16. (a) Informant Tom Huffstutler

(b) Address Naylor, Mo. R.F.

17. (a) Burial (b) Date thereof 8-15-45  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation New Hope Cem

18. (a) Signature of funeral director W.H. Deby

(b) Address Coring, Ark

19. (a) Sept 12 45 (b) Beth White  
(Date received local registrar) (Registrar's signature)

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions Interstitial nephritis  
(Include pregnancy within 3 months of death)

Major findings:  
Of operations \_\_\_\_\_

Of autopsy 3/10

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 Stehmer MD (M. D. or other)

Address Coring, Ark. Date signed 8/16/45

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

MOTHER FATHER

RECEIVED

District Health Officer No. 5,

District File Number 945-354

Date Filed 9-10-45

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 Delbert Johnson

Licensed Embalmer No. 686 + 4271

P. O. Address Crossing, Ark

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.