

FILED NOV 8 1945
Registration District No. 72

Primary Registration District No. 4124

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

1. PLACE OF DEATH:

(a) County CLAY
(b) City or town SMITHVILLE, MO.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: SMITHVILLE COMMUNITY HOSPITAL
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 6 DAYS (Specify whether
In this community LIFETIME
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO. (b) County PLATTE
(c) City or town SMITHVILLE, MO. R.F.D.
(If outside city or town limits, write "RURAL")
(d) Street No. _____
(If rural, give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME THOMAS MARION HUFFORD

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 FANNIE BULLOCK HUFFORD 6. (c) Age of husband or wife if alive 70 years

7. Birth date of deceased Oct. 8, 1875
(Month) (Day) (Year)

8. AGE: Years 70 Months 2 Days 27 If less than one day
hr. _____ min. _____

9. Birthplace PLATTE COUNTY MO.
(City, town, or county) (State or foreign country)

10. Usual occupation FARMER

11. Industry or business _____

MOTHER FATHER { 12. Name ALFRED HOWARD HUFFORD

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

14. Maiden name MARTHA SOWARD

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

16. (a) Informant MRS. T. M. HUFFORD

(b) Address SMITHVILLE, MO. R.F.D.

17. (a) BURIAL (b) Date thereof 10/10/45
(Burial, cremation, etc.) (City or town) (County) (State) (Day) (Year)

(c) Place: burial or cremation SECOND CREEK CEM. PLATTE CO., MO.

(d) Signature of funeral director McComas Funeral Home

(b) Address Smithville Mo.

19. (a) Oct 10 - 1945 (b) Basileh Kitchener
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month OCT. day 8,
year 1945 hour 2:30 minute 8 M.

21. I hereby certify that I attended the deceased from Oct 1, 1945 to Oct 8, 1945
that I last saw him alive on Oct 7, 1945
and that death occurred on the date and hour stated above.

Immediate cause of death Coronary Thrombosis
Due to _____
Due to _____

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

Major findings: Of operations _____

Of autopsy _____

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 FRN [Signature] (M. D. or other) MS

Address Smithville, Mo Date signed 10-8-45

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

1411

RECEIVED

District Health Officer No. 8,

District File Number _____

Date Filed 11-6-75

AUG 21 1981

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

S. A. McComas

Licensed Embalmer No.

2303

P. O. Address

Smithville, 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.