No. 2
9-4-41
-17-39
X29484

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

FILED DEC 6 1945

State File No. 37014

Registration District No. 93 Primary Registration District No. 5340 Registrar's No. 16

1. PLACE OF DEATH:

(a) County: Dade

(b) City or town: Smith Twp. (If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Rural, Lockwood Mo. (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution ..... In this community: about one year (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State: Missouri (b) County: Dade

(c) City or town: Lockwood Rural (If outside city or town limits, write "RURAL")

(d) Street No.: R.F.D. #3 (If rural, give location)

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

If yes, name country .....

3. (a) PRINT FULL NAME: Alice Huffman

3. (b) If veteran, name war: 0

3. (c) Social Security No.: 0

4. Sex: F

5. Color or race: White

6. (a) Single, widowed, married, divorced: Widow

6. (b) Name of husband or wife: John L. Huffman

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

7. Birth date of deceased: March (Month) 25 (Day) 1857 (Year)

8. AGE: Years 88 Months 7 Days 12 If less than one day ..... hr. ..... min.

9. Birthplace: Clark County Mo (City, town, or county) (State or foreign country)

10. Usual occupation: Keeping home with her

11. Industry or business: Wife & Family

MOTHER FATHER

12. Name: David Huffman

13. Birthplace: Clark County Mo (City, town, or county) (State or foreign country)

14. Maiden name: Elvira Randolph

15. Birthplace: Shelby Co. Ind. (City, town, or county) (State or foreign country)

16. (a) Informant: Guy Huffman

(b) Address: Lockwood Mo.

17. (a) Disposal (Burial, cremation, or removal) (b) Date thereof: Nov. 7-1945 (Month) (Day) (Year)

(c) Place: burial or cremation: Burial Mena, Okla

18. (a) Signature of funeral director: E. Ray Caldwell

(b) Address: Lockwood Mo.

19. (a) Nov. 6-1945 (Date received local registrar) (b) Geo. L. Weir (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov. 6 day 6 year 1945 hour 2:00 P.M. A.M.

21. I hereby certify that I attended the deceased from Oct 30 1945 to Nov 6 1945 that I last saw her alive on Nov 2 1945 and that death occurred on the date and hour stated above.

Immediate cause of death: Senility

Due to: Fractured hip

Due to:

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

Major findings: Of operations:

Of autopsy:

Duration

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

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? (Specify type of place)

While at work? (e) Means of injury

23. Signature: James O. Wren (M.D. or other)

Address: Lockwood Mo Date signed 11-6-45

(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~~ .....

....., Reg~~istered~~ Apprentice No. .....

wor~~king under my personal supervision~~.

Signed. E. Ray Caldwell

Lic~~ensed~~ Embalmer No. 3380

P. O. Address Lockwood, Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wi the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

2nd Entry

S. No. 2B
M—3-45
I X43880

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 37014

Registration District No. 93 Primary Registration District No. 5340 Registrar's No. 11

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

1. PLACE OF DEATH:
(a) County Dade
(b) City or town Lockwood Rural
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(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 about 1 yr

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County
(c) City or town
(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 Alice Huffman
3. (b) If veteran, name war OL
3. (c) Social Security No.
4. Sex F
5. Color or race w
6. (a) Single, widowed, married, divorced Wd.
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive years
7. Birth date of deceased Mar 25 1855 (Month) (Day) (Year)
8. AGE: Years 88 Months Days If less than one day hr. min.
9. Birthplace Mo. (City, town, or county) (State or foreign country)
10. Usual occupation
11. Industry or business
MOTHER FATHER
12. Name
13. Birthplace (City, town, or county) (State or foreign country)
14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)
16. (a) Informant
(b) Address
17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation
18. (a) Signature of funeral director
(b) Address
19. (a) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov. Day 6 year 1943 hour minute M.
21. I hereby certify that I attended the deceased from , 19 , to , 19 ;
that I last saw h alive on , 19 ;
and that death occurred on the date and hour stated above.
Immediate cause of death — Duration
Due to Broken neck of Femur
Due to
Other conditions
(Include pregnancy within 3 months of death)
Major findings:
Of operations
Of autopsy

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) Accident
(b) Date of occurrence Oct 1
(c) Where did injury occur? At Home
(City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? Home or farm
(Specify type of place)
While at work? (e) Means of injury
23. Signature Yancy A Wren (M. D. or ~~other~~)
Address Lockwood Date signed

SUPPLEMENTARY

Slow 16