

3. No. 2
-12-45
5-17-39
PI X47070

FILED MAR 6 1947

Registration District No. 517

Primary Registration District No. 6076

Registrar's No. 318

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

1. PLACE OF DEATH:

(a) County St. Louis

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

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

(d) Length of stay: In hospital or institution since 1-31-47
(Specify whether years, months or days)

In this community 18 years
(Specify whether years, months or days)

3. (a) PRINT FULL NAME Huff, Hubert W.

3. (b) If veteran, name war World War I

3. (c) Social Security No. 490-03-1313

4. Sex male 5. Color or race white

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

6. (b) Name of husband or wife Marguerite Huff

6. (c) Age of husband or wife if alive 47 years

7. Birth date of deceased September 23 1896
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>50</u>	<u>4</u>	<u>24</u>	<u>8 hr. 30 min.</u>

9. Birthplace: Ft. Scott, Kansas
(City, town, or county) (State or foreign country)

10. Usual occupation Engineer (electrical)

11. Industry or business St. Joseph Lead Co.

MOTHER FATHER

12. Name Walter S. Huff

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

14. Maiden name Ruby Squire

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

16. (a) Informant Registrar, Vet. Adm. Hospital

(b) Address Jefferson Barracks, Missouri

17. (a) Burial (b) Date thereof 2 - 19-47
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St. Francois Meo. Pk.

18. (a) Signature of funeral director C. Z. Boyer Undertaking

(b) Address CO., Desloge, Mo.

19. (a) 2-20-47 (b) Reuben J. Allen, M.D.
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Francis 94

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

(d) Street No. Box 361
(If rural, give location)

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

If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month February day 16 year 1947 hour 8:30 minute _____ A.M.

21. I hereby certify that I attended the deceased from 1-31-47 to 2-16-47, 19____; that I last saw him alive on 2-16-47, 19____; and that death occurred on the date and hour stated above.

Immediate cause of death MULTIPLE MYELOMA Duration UNK.

Due to _____

Due to _____

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations No operations

Of autopsy Autopsy performed (See Cause of Death)

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) no

(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 0

23. Signature L. E. Stilwell (M. D. or other) _____
L. E. STILWELL, M.D.
Address Vet. Adm. Hosp., Jeff. Bks., Mo. Date signed 2-17-47

MAR 20 1947

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: Elmo R. Cadwell
Licensed Embalmer No. 4077
P. O. Address.....

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.