

FILED JUL 26 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 24240

BIRTH NO. _____ REG. DIST. NO. 254 PRIMARY REG. DIST. NO. 4385 Registrar's No. 34

1. PLACE OF DEATH a. COUNTY Oregon		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Oregon	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Koshkonong		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Koshkonong	
c. LENGTH OF STAY (in this place) Lifetime		d. STREET ADDRESS (If rural, give location)	
d. FULL NAME OF HOSPITAL OR INSTITUTION			

3. NAME OF DECEASED (Type or Print) a. (First) George b. (Middle) Willie Huddleston c. (Last)			4. DATE OF DEATH (Month) (Day) (Year) 3---29---1949	
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5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH 5-4-1893	9. AGE (In years last birthday) 55	IF UNDER 1 YEAR Months 10	IF UNDER 24 HRS. Hours 25
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Saw mill Operator	10b. KIND OF BUSINESS OR INDUSTRY Saw mill	11. BIRTHPLACE (State or foreign country) Oregon county	12. CITIZEN OF WHAT COUNTRY? USA
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13a. FATHER'S NAME Henry Huddleston	13b. MOTHER'S MAIDEN NAME Effie Heard	14. NAME OF HUSBAND OR WIFE Edna Huddleston
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME Edna Huddleston	ADDRESS Koshkonong, Missouri
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH 2 weeks A530
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Hemolytic Streptococcus		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Throat infection DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from Mar 21, 1949, to Mar. 28, 1949, that I last saw the deceased alive on Mar 28, 1949, and that death occurred at _____ m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Mitchell Blaine MD	23b. ADDRESS Mammoth Spring Ark	23c. DATE SIGNED 6-7-49
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 4---1---1949	24c. NAME OF CEMETERY OR CREMATORY Koshkonong cemetery	24d. LOCATION (City, town, or county) (State) Koshkonong, Missouri
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DATE REC'D BY LOCAL REG. July 7-49	REGISTRAR'S SIGNATURE Ella Crass	416	25. FUNERAL DIRECTOR'S SIGNATURE	ADDRESS
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BLAINE

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

RECEIVED 7-12-49
District Health Officer No. 5,
District File Number 749525
Date Filed 7-22-49

AUG 2 1949

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 _____

..... Student Embalmer No.
working under my personal supervision.

Signed.....
Student Embalmer

Signed

Richard Carter

Licensed Embalmer No. 4576

P. O. Address Shawnee, 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.