

THE DIVISION OF HEALTH OF MISSOURI
 STANDARD CERTIFICATE OF DEATH

State File No. **25912**

FILED AUG 12 1949

BIRTH NO. _____ REG. DIST. NO. **367** PRIMARY REG. DIST. NO. **4537** Registrar's No. **12**

1. PLACE OF DEATH a. COUNTY WASHINGTON 1		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE MO b. COUNTY Washington	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN IRONDALE		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Irondale 110	
c. LENGTH OF STAY (in this place)		d. STREET ADDRESS (If rural, give location) NONE	
d. FULL NAME OF HOSPITAL OR INSTITUTION NONE			

3. NAME OF DECEASED (Type or Print)	a. (First) BETTY	b. (Middle) JANE	c. (Last) HUFF	4. DATE OF DEATH (Month) (Day) (Year) AUGUST 5 1949
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5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) MARRIED	8. DATE OF BIRTH FEB 25, 1924	9. AGE (In years last birthday) 25	IF UNDER 1 YEAR Months	IF UNDER 1 YEAR Days	IF UNDER 1 MIN. Hours	IF UNDER 1 MIN. Mins.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE	10b. KIND OF BUSINESS OR INDUSTRY NONE	11. BIRTHPLACE (State or foreign country) MICHIGAN	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13a. FATHER'S NAME BERT ARNOLD SNYDER	13b. MOTHER'S MAIDEN NAME MARGARET SCOTT	14. NAME OF HUSBAND OR WIFE EZRA HUFF
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO	16. SOCIAL SECURITY NO. 498-26-1225	17. INFORMANT'S SIGNATURE OR NAME EZRA HUFF	ADDRESS IRONDALE, MO
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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, ashenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Past Painless Hemorrhage		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Hemorrhage of birth		
DUE TO (c)		672X	
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 checked="" 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 **July 4, 1944**, to **Aug 4, 1949**, that I last saw the deceased alive on **Aug 4, 1949**, and that death occurred at **4:9** m., from the causes and on the date stated above.

23a. SIGNATURE Jus. W. Hoffmann M.D. (Degree or title)	23b. ADDRESS Bismarck, MO	23c. DATE SIGNED Aug 5-49
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24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	24b. DATE 8/7/49	24c. NAME OF CEMETERY OR CREMATORY HUFF CEMETERY	24d. LOCATION (City, town, or county) (State) WASHINGTON COUNTY, MO
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DATE REC'D BY LOCAL REG. Aug. 7, 1949	REGISTRAR'S SIGNATURE Jessie Eichenberger	3345 FUNERAL DIRECTOR'S SIGNATURE Bert K. Boyer Leadwood, Mo.	ADDRESS
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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AUG 18 1949

RECEIVED 8-8-49
Health Officer No. 4
File Number 849-1060
Date Filed

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.

Student
Student Embalmer

Signed Bert L. Boyer

Licensed Embalmer No. 3445

P. O. Address Leadwood 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.