

THE DIVISION OF HEALTH OF THE STATE OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **9439**
Registrar's No. **359**

FILED APR 14 1953
30231

BIRTH NO. _____ REG. DIST. NO. **128** PRIMARY REG. DIST. NO. **2000**

1. PLACE OF DEATH a. COUNTY GREENE		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Mo. b. COUNTY LACLEDE	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Springfield		c. LENGTH OF STAY (In this place)	
c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN LACLEDE CO, BOX 412		d. STREET ADDRESS (If rural, give location) 0530	
d. FULL NAME OF HOSPITAL OR INSTITUTION Burge Hospital			

3. NAME OF DECEASED (Type or Print) a. (First) Freddie	b. (Middle) Lee	c. (Last) Hufft.	4. DATE OF DEATH (Month) (Day) (Year) 4-4-53
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5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Never Married	8. DATE OF BIRTH MAY 9, 1952	9. AGE (In years) (Months) (Days) (Hours) (Min.) 11 25
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY (Child)	11. BIRTHPLACE (City and State or Foreign Country) Lebanon, Mo.	12. CITIZEN OF WHAT COUNTRY? USA
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13a. FATHER'S NAME HAROLD LELAND HUFFT.	13b. MOTHER'S MAIDEN NAME HELEN LOONEY	14. NAME OF HUSBAND OR WIFE
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME D. J. Hagwood, M.D.	ADDRESS Burge Hosp.
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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 4-2-53 - 4-4-53
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) VOLVULUS		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Meckel's diverticulum DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Iron deficiency anaemia.			

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. PLACE OF INJURY 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)
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?

22. I hereby certify that I attended the deceased from **DEAD ON ARRIVAL**, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at **ABOUT 12:00 NOON**, from the causes and on the date stated above.

23a. SIGNATURE E. J. Houston, M.D. (Degree or title)	23b. ADDRESS Revere Hosp	23c. DATE SIGNED 4-5-53
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24a. BURIAL - CREMATION - REMOVAL (Specify)	24b. DATE 4-4-53	24c. NAME OF CEMETERY OR CREMATORY Bella	24d. LOCATION (City, town, or county) (State) Lebanon Laclede Mo
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DATE REC'D BY LOCAL REG. 4-9-53	REGISTRAR'S SIGNATURE Edith Williamson	25. FUNERAL DIRECTOR'S SIGNATURE S. R. Palmer ADDRESS Lebanon Mo
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(Licensed Embalmer's Statement on Reversed Side)

No. 300 10.48
WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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 S. R. Palmers

Licensed Embalmer No. 2208

P. O. Address Lebanon 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.