

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

FILED AUG 12 1953

State File No. **24030**

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **43** PRIMARY REG. DIST. NO. **3007** Registrar's No. **328**

1. PLACE OF DEATH a. COUNTY <b>Butler</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Stoddard</b>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>Poplar Bluff</b>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>Rural Castor</b>	
c. LENGTH OF STAY (In this place) <b>3 weeks</b>		1030 /	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>Brandon Hospital</b>		d. STREET ADDRESS (If rural, give location) <b>Bloomfield, Mo. R # 3</b>	

3. NAME OF DECEASED (Type or Print)	a. (First) <b>Elizibeth</b>	b. (Middle) <b>M.</b>	c. (Last) <b>Huggins</b>	4. DATE OF DEATH (Month) (Day) (Year) <b>July 30, 1953</b>
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5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Widowed</b>	8. DATE OF BIRTH <b>June 23, 1879</b>	9. AGE (In years) (Months) (Days) (Hours) (Min.) <b>74 1 7</b>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>--</b>	11. BIRTHPLACE (City and State or Foreign Country) <b>Missouri Stoddard Co.</b>	12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>
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13a. FATHER'S NAME <b>David Rose</b>	13b. MOTHER'S MAIDEN NAME <b>Martha Barham</b>	14. NAME OF HUSBAND OR WIFE <b>William H. Huggins Dec.</b>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>	16. SOCIAL SECURITY NO. <b>--</b>	17. INFORMANT'S SIGNATURE OR NAME ADDRESS <b>Mrs. Sylvia Bess Bloomfield, Mo. R3</b>
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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  <b>443X F</b>
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Cardiac failure</b>		
	ANTECEDENT CAUSES DUE TO (b) <b>Hypertension</b> DUE TO (c) <b>Cardiovascular disease with congestive heart failure.</b>		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <b>1. Arterio sclerosis obliterans, incomplete both lower limbs. 2. Trochanteric fracture right hip.</b>			

19a. DATE OF OPERATION <b>7-15-53</b>	19b. MAJOR FINDINGS OF OPERATION <b>Trochanteric fracture right hip</b>	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify) <b>Accident</b>	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>Home</b>	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <b>Bloomfield Stoddard Mo.</b>
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	21f. HOW DID INJURY OCCUR? <b>Fall</b>

22. I hereby certify that I attended the deceased from **7-12-53**, 19\_\_\_\_, to **7-30-53**, 19\_\_\_\_, that I last saw the deceased alive on **7-30-53**, 19\_\_\_\_, and that death occurred at **9:55P m.**, from the causes and on the date stated above.

23a. SIGNATURE <b>S. A. Semetich M.D.</b>	23b. ADDRESS <b>733 Poplar St, Poplar Bluff, Mo.</b>	23c. DATE SIGNED <b>8/4/53</b>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	24b. DATE <b>8-1-53</b>	24c. NAME OF CEMETERY OR CREMATORY <b>Bloomfield Cemetery</b>	24d. LOCATION (City, town, or county) (State) <b>Bloomfield Stoddard Mo.</b>
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DATE RECD BY LOCAL REG. <b>8/8/53</b>	REGISTRAR'S SIGNATURE <b>[Signature]</b>	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>Chiles Und. Co. Bloomfield, Mo.</b>
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(Licensed Embalmer's Statement on Reverse Side)

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

RECEIVED  
AUG 10 1958

BUTLER CO. HEALTH CENTER

FILE No. \_\_\_\_\_

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 Lulu

Chapin # 3499

Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student .....  
Student Embalmer

Signed Juan C. Cooper

Licensed Embalmer No. 4119

P. O. Address Bloomfield, 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.