

FILED NOV 29 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 36583

BIRTH NO. _____		REG. DIST. NO. <u>42</u>		PRIMARY REG. DIST. NO. <u>1000</u>		Registrar's No. <u>1230</u>	
1. PLACE OF DEATH a. COUNTY <u>Buchanan</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Arkansas</u> b. COUNTY <u>Clay</u>			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Joseph</u>			c. LENGTH OF STAY (In this place) <u>3 Months</u>	c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Corning</u>			d. STREET ADDRESS (If rural, give location) <u>None</u>
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Mo. Methodist Hospital</u>							
3. NAME OF DECEASED (Type or Print) a. (First) <u>JAMES</u> b. (Middle) <u>NEWTON</u> c. (Last) <u>HUDDLESTON</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>Nov. 22 1954</u>				
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, <u>2</u> WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH <u>Dec. 17, 1870</u>		9. AGE (In years last birthday) <u>83</u>	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 10 HRS. Hour <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ret. Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>		11. BIRTHPLACE (State or foreign country) <u>Illinois</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>	
13a. FATHER'S NAME <u>George W. Huddleston</u>		13b. MOTHER'S MAIDEN NAME <u>Sarah Woodside</u>		14. NAME OF HUSBAND OR WIFE <u>Ida Mae (Deceased)</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	17. INFORMANT'S SIGNATURE OR NAME <u>Mrs. Alice Wood</u> ADDRESS <u>St. Joseph, Mo.</u>				
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 I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cardiac Asthma</u> INTERVAL BETWEEN ONSET AND DEATH <u>10 days</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Cardiac decompensation</u> DUE TO (c) <u>Gen. Arteriosclerosis</u> II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Gen. Dermatitis</u>						
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION <u>4343</u>				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
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) _____			
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 <u>11-16-1954</u> to <u>11-22-1954</u> , that I last saw the deceased alive on <u>11-22-1954</u> , and that death occurred at <u>12:45 Pm.</u> , from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <u>Dr. E. E. Smith M.D.</u>				23b. ADDRESS <u>St. Joseph Mo</u>		23c. DATE SIGNED <u>11-23-54</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		24b. DATE <u>Nov. 24, 1954</u>	24c. NAME OF CEMETERY OR CREMATORIUM <u>Corning Cemetery</u>		24d. LOCATION (City, town, or county) (State) <u>Corning, Arkansas</u>		
DATE RECD BY LOCAL REG. <u>Nov 26, 1954</u>	REGISTRAR'S SIGNATURE <u>Kathleen M. Allison</u>			25. FUNERAL DIRECTOR'S SIGNATURE <u>Stancy Funeral Home</u>		ADDRESS <u>St. Joseph, Mo.</u>	

(Licensed Embalmer's Statement on Reverse Side)

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 _____

working under my personal supervision.

Student Embalmer No.

Signed _____

Charles E. Bennett

Signed.....
Student Embalmer

Licensed Embalmer No. *4677*

P. O. Address _____

St Joseph 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.