

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-005246
STATE FILE NUMBER

FILED FEB 17 1958

Registration District No. 133 Primary Registration District No. 3022 Registrar's No. 41

300
1-57

1. PLACE OF DEATH a. COUNTY <u>Harrison</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Harrison</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Bethany</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Bethany</u> 0410 Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Reid Hospital</u>		Length of stay in Hosp <u>33 hours</u>	d. STREET ADDRESS (If outside, give location) <u>1615 Alder</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>Howard</u> Middle <u>Burton</u> Last <u>Huff</u>			4. DATE OF DEATH Month <u>Feb.</u> Day <u>9</u> Year <u>1958</u>			
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5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 8, 1886</u>	9. AGE (In years last birthday) <u>71</u>	IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u>	IF UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farm Owner</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Farm</u>	11. BIRTH PLACE (City and state or country) <u>Bethany, Missouri</u>	12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>
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13a. FATHER'S NAME <u>William S. Huff</u>	13b. MOTHER'S MAIDEN NAME <u>Mary E. Pierce</u>	14. NAME OF HUSBAND OR WIFE <u>Pearl Huff (Deceased)</u>
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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) <u>No</u>	16. SOCIAL SECURITY NO. <u>493-34-9087</u>	17. INFORMANT <u>Cecil Huff, 6115 Place, Carroll, Iowa</u>	Address
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u>		INTERVAL BETWEEN ONSET AND DEATH <u>0</u> days
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>Hypertensive Heart Disease</u>	
	DUE TO (c) _____	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>443X</u>		19. WAS AUTOPSY PERFORMED? <u>2</u> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>

20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
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20c. TIME OF INJURY Hour _____ a.m. _____ p.m.	20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION <u>Bethany, Missouri</u>	COUNTY <u>Daviess</u>	STATE <u>Missouri</u>
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21. I attended the deceased from <u>1-15-58</u> to <u>2-9-58</u> and last saw <u>him</u> alive on <u>2-9-58</u> Death occurred at <u>8:00 P.M.</u> m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>Gullent H. Thurg D.O.</u>	22b. ADDRESS <u>Bethany, Missouri</u>	22c. DATE SIGNED <u>2-12-58</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>2-12-58</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Bethel Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Daviess County Missouri</u>
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24. FUNERAL DIRECTOR <u>Noble Wheeler Funeral Home Bethany, Mo</u>	25. DATE RECD. BY LOCAL REG. <u>2-12-1958</u>	26. REGISTRAR'S SIGNATURE <u>Gella Mayer</u>
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(Licensed Embalmer's Statement on Reverse Side)

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION

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FEB 20 1958

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
Signature of Student Embalmer

Signed *Clark L. Goudets*

Licensed Embalmer No. *4831*

P. O. Address *Bethany, Md*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.