Health, Welfare Public Service

300
1-56

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

FILED MAR 19 1958

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-011792
STATE FILE NUMBER

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 2849

1. PLACE OF DEATH
a. COUNTY ~~St. Louis~~
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis — Inside Limits Yes ☐ No ☐
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location) 40 MISSOURI PACIFIC HOSP — Length of stay in 1b 4 days
d. STREET ADDRESS (If outside, give location) 665 S. O'dell — Reside on Farm Yes ☐ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Missouri b. COUNTY Saline
c. CITY OR TOWN 31 Marshall 0972 — Inside Limits Yes ☐ No ☐

3. NAME OF DECEASED (Type or print) First ONEY Middle CLEO Last HUFF
4. DATE OF DEATH Month MARCH Day 7th Year 1958
5. SEX M
6. COLOR OR RACE WHITE
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒ 3
8. DATE OF BIRTH 15 Aug. 1901
9. AGE (In years last birthday) 56 — IF UNDER 1 YEAR Months 6 Days 22 — IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Coach Painter
10b. KIND OF BUSINESS OR INDUSTRY Mo. Pac. R.R.
11. BIRTHPLACE (City and state or country) Smithton, Mo.
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME John Huff
14. MOTHER'S MAIDEN NAME Florence Schrader
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 702-16-1783
17. INFORMANT Address Mrs. Earl Wenig Marshall, Mo.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CHRONIC DUODENAL ULCER BLEEDING — INTERVAL BETWEEN ONSET AND DEATH 3 days
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b)
DUE TO (c) 541.0
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year
20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
20f. CITY, TOWN, OR LOCATION COUNTY STATE

21. I attended the deceased from Mar 5 1958, to MARCH 7th 1958 and last saw him alive on MARCH 7th 1958
Death occurred at 8:35 P m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) John T Vandver MD
22b. ADDRESS 1504 So Grand
22c. DATE SIGNED 3/8/58

23a. BURIAL, CREMATION, REMOVAL (Specify) Removal
23b. DATE March 7, 1958
23c. NAME OF CEMETERY OR CREMATORY Crown Hill Cemetery
23d. LOCATION (City, town, or county) (State) Sedalia, Missouri

24. FUNERAL DIRECTOR ADDRESS Gillespie Funeral Home, Sedalia, Mo.
25. DATE RECD. BY LOCAL REG. MAR 11 '58
26. REGISTRAR'S SIGNATURE J Earl Smith MD MRB

(Licensed Embalmer's Statement on Reverse Side)

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was em

by me, or by ....., Student Embalmer No.....

working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed W. Embalmer
Ernest W. Williams
Licensed Embalmer No.....

P. O. Address .....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (
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.