

DEPARTMENT OF HEALTH - STANDARD CERTIFICATE OF DEATH  
 FILED VS JAN - 8 1960

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 STATE FILE NUMBER

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>ILLINOIS</b> b. COUNTY <b>MADISON</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>915 N GRAND ST LOUIS MO</b>	Length of stay in 1b <b>58 DAYS</b>	c. CITY OR TOWN <b>GRANITE CITY</b>	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>VETS ADMIN HOSPITAL</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>2520 DELMAR</b>

3. NAME OF DECEASED (Type or print) First <b>WILLIAM</b> Middle <b>R.</b> Last <b>HUFF</b>			4. DATE OF DEATH Month <b>DECEMBER</b> Day <b>24</b> Year <b>1959</b>			
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>11/21/91</b>	9. AGE (last birthday) <b>68</b>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED</b>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <b>TROY, INDIANA</b>		12. CITIZEN OF WHAT COUNTRY <b>USA</b>	
13a. FATHER'S NAME <b>CHARLES HUFF</b>		13b. MOTHER'S MAIDEN NAME <b>MARY JONES</b>		14. NAME OF HUSBAND OR WIFE <b>CHRISTINA HUFF</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>YES WW I</b>		16. SOCIAL SECURITY NO. <b>UNK.</b>	17. INFORMANT Address <b>VA HOSP RECORDS 915 N GRAND ST LOUIS MO.</b>			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	<b>ACUTE &amp; CHRONIC CHOLECYSTITIS WITH</b>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	<b>PERFORATION OF GALL BLADDER.</b>	
DUE TO (b)		
DUE TO (c)		<b>585x</b>

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>DIABETES MELITUS</b>		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
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19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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.)	
20c. TIME OF INJURY Hour _____ a.m. _____ p.m. _____	Month, Day, Year		
20d. INJURY OCCURRED WHILE AT WORK <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	COUNTY STATE

21. attended the deceased from **10/27/59** to **12/24/59** and last saw ~~him~~ <sup>her</sup> alive on **12/24/59**  
 Death occurred at **2:20 PM** on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <b>JAMES M. BLACK M.D.</b>	22b. ADDRESS <b>VAH, ST LOUIS, MO.</b>	22c. DATE SIGNED <b>12/24/59</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>REMOVAL</b>	23b. DATE <b>12-28-59</b>	23c. NAME OF CEMETERY OR CREMATORY <b>SUNSET HILL CEMETERY</b>	23d. LOCATION (City, town, or county), (State) <b>EDWARDSVILLE, ILLINOIS</b>
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24. FUNERAL DIRECTOR ADDRESS <b>Frank Mercer Granite City Ill</b>	25. DATE RECD. BY LOCAL REG. <b>DEC 28 1959</b>	26. REGISTRAR'S SIGNATURE <b>Carl Smith M.D.</b>
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m. g. B

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed Charles E. Moore

Licensed Embalmer No. 2980

P. O. Address Granite

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.