

REGISTRATION DISTRICT NO. 1 Primary Registration District No. 3000 Registrar's No. 11

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS JAN 25 1960

60-000017

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY Adair				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY Adair									
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kirksville		Length of stay in 1b 45 yrs		c. CITY OR TOWN Kirksville		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>							
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Kirksville Osteopathic			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) 1023 E. Harrison		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) First Middle Last LILLIAN HUFFMAN				4. DATE OF DEATH Month Day Year Jan. 20 1960									
5. SEX Female		6. COLOR OR RACE White		7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH 12/9/85		9. AGE (last birthday) 74		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HR	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker			10b. KIND OF BUSINESS OR INDUSTRY own home			11. BIRTHPLACE (City and state or country) Scotland Co. Mo.			12. CITIZEN OF WHAT COUNTRY U S				
13a. FATHER'S NAME James Wm. Shriver				13b. MOTHER'S MAIDEN NAME Dora Baker				14. NAME OF HUSBAND OR WIFE James E. Huffman					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. None		17. INFORMANT Address Juanita Jones, Quincy, Ill.							
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>medullary Failure</u> DUE TO (b) <u>metastatic malignancy</u> DUE TO (c) <u>Leisomyosarcoma of liver</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 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										INTERVAL BETWEEN ONSET AND DEATH 15 min. 5 yrs. 10 yrs.			
19. WAS AUTOPSY PERFORMED? 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.)									
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. I attended the deceased from <u>1-29-1956</u> to <u>1-20-1980</u> and last saw her ^{from} alive on <u>1-20-1960</u> Death occurred at <u>2:12 am</u> on the date stated above, and to the best of my knowledge, from the causes stated.													
22a. SIGNATURE <u>R. G. Maddox, DO</u> (Degree or title)						22b. ADDRESS <u>Kirksville Osteopathic Hosp.</u>			22c. DATE SIGNED <u>1-21-1960</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City, town, or county) (State)						
Burial		1/22/60		Maple Hill			Kirksville, Adair, Mo.						
24. FUNERAL DIRECTOR <u>Nora B. Foster</u> ADDRESS Foster Memorial Home, Kirksville, Mo.					25. DATE RECD. BY LOCAL REG. <u>1-21-1960</u>		26. REGISTRAR'S SIGNATURE <u>Nora W. Ratliff</u>						

DOCUMENT

MEDICAL CERTIFICATION MADDOX

BY AFFIDAVIT OF

D. E. Maddox, D. O.

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 *Nova E. Foster*
Nova E. Foster

Licensed Embalmer No. 4742

P. O. Address Kirksville, 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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.