

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS FEB 1 1960

=60-001625

230

STATE FILE NUMBER

Registration District No. 149 Primary Registration District No. 1002 Registrar's No.

|  |   |   |  |   |  |   |  |       |
|--|---|---|--|---|--|---|--|-------|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Jackson</b>  |   |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Missouri</b> COUNTY <b>Jackson</b> |  |   |  |       |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR TOWN <b>Kansas City</b>  |   | Length of stay in 1b<br><b>50 yrs.</b>  |  | c. CITY OR TOWN <b>Kansas City</b>  |  | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>  |  |       |
| c. FULL NAME OF (If NOT in hospital, give location)<br>HOSPITAL OR INSTITUTION <b>5401 Troost</b>  |   |   | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | d. STREET ADDRESS (If outside, give location)<br><b>5332 Virginia</b>   |  | Reside on Farm<br>Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |  |       |
| 3. NAME OF DECEASED (Type or print)<br>First <b>THOMAS</b> Middle <b>J.</b> Last <b>HUFFMAN</b>  |   |   |  | 4. DATE OF DEATH<br>Month <b>January</b> Day <b>13</b> Year <b>1960</b>   |  |   |  |       |
| 5. SEX<br><b>Male</b>  | 6. COLOR OR RACE<br><b>White</b>  | 7. Married <input type="checkbox"/> Never Married <input type="checkbox"/><br>Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><b>5-9-1876</b>   | 9. AGE (last birthday)<br><b>83</b>  | IF UNDER 1 YEAR<br>Months <input type="checkbox"/> Days <input type="checkbox"/>      | IF UNDER 24 HR<br>Hours <input type="checkbox"/> Min. <input type="checkbox"/> |       |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Retired Clerk</b>  |   |   | 10b. KIND OF BUSINESS OR INDUSTRY  |   | 11. BIRTHPLACE (City and state or country)<br><b>Naples, Illinois</b>  |   | 12. CITIZEN OF WHAT COUNTRY<br><b>U.S.A.</b>                                   |       |
| 13a. FATHER'S NAME<br><b>Samuel R. Huffman</b>   |   |   | 13b. MOTHER'S MAIDEN NAME<br><b>Lydia Ann McDowell</b>                               |   |  | 14. NAME OF HUSBAND OR WIFE<br><b>Mary --</b>   |  |       |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><b>No</b>  |   |   | 16. SOCIAL SECURITY NO.<br><b>490-16-4677</b>  |   | 17. INFORMANT<br><b>Miss Ray Huffman</b> Address <b>5332 Virginia</b>  |   |  |       |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b>   |   |   |  |   |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>6 mo</b>                                       |  |       |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.<br>DUE TO (b) _____<br>DUE TO (c) _____   |   |   |  |   |  |   |  |       |
| 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.<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown |   |  |       |
| 19. WAS AUTOPSY PERFORMED?<br>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<br>Hour _____ a.m. _____ p.m.<br>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 <b>1/10/59</b> to <b>1/12/60</b> and last saw him alive on <b>1/10/60</b><br>Death occurred at <b>2 P.M.</b> on the date stated above, and to the best of my knowledge, from the causes stated. |   |   |  |   |  |   |  |       |
| 22a. SIGNATURE (Degree or title)<br><b>H.S. Prentiss M.D.</b>  |   |   |  | 22b. ADDRESS<br><b>900 Realty Bldg - 110 Mo</b>   |  | 22c. DATE SIGNED<br><b>1/14/60</b>  |  |       |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |   | 23b. DATE<br><b>Jan. 15, 1960</b>   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Mt. Washington</b>                          |   | 23d. LOCATION (City, town, or county) (State)<br><b>Kansas City, Missouri</b>  |   |  |       |
| 24. FUNERAL DIRECTOR<br><b>Freeman Mortuary</b> ADDRESS <b>Kansas City, Mo.</b>  |   |   | 25. DATE RECD. BY LOCAL REG.<br><b>1-14-60</b>                                       |   | 26. REGISTRAR'S SIGNATURE<br><b>Neva Minchell</b>  |   |  |       |

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF H. S. Prentiss

*Tr: P... ..*

*... ..*

**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 *J. P. Green*

Licensed Embalmer No. 29

P. O. Address F. O. ...

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.