

FEDERAL DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-024259

FILED VS JUL 6 1960

STATE FILE NUMBER

Registration District No. 316 Primary Registration District No. Registrar's No. 261

| | | | | | | | | | |
|---|----------------------------------|---|--|--|---|---|---|---|------------------------|
| 1. PLACE OF DEATH a. COUNTY ST FRANCOIS | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURI b. COUNTY ST FRANCOIS | | | | | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Farmington, rural | | Length of stay in 1b | | c. CITY OR TOWN FARMINGTON | | Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | | | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION RFD#3 | | | Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | | d. STREET ADDRESS (If outside, give location) RT. THREE | | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | | |
| 3. NAME OF DECEASED (Type or print) First CLEVA Middle DOT Last HUFF | | | | 4. DATE OF DEATH Month JUNE Day 19 Year 1960 | | | | | |
| 5. SEX FEMALE | 6. COLOR OR RACE WHITE | 7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | | 8. DATE OF BIRTH 3-31-1910 | 9. AGE (last birthday) 50 | IF UNDER 1 YEAR Months | IF UNDER 24 HR Days | IF UNDER 24 HR Hours | IF UNDER 24 HR Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (City and state or country) CENTRALIA ILL. | | 12. CITIZEN OF WHAT COUNTRY U.S.A. | | |
| 13a. FATHER'S NAME LENNIE ROAN THOMAS | | | 13b. MOTHER'S MAIDEN NAME NANCY ELIZABETH SHAW | | | 14. NAME OF HUSBAND OR WIFE CLARK HUFF | | | |
| 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. | | 17. INFORMANT Address CLARK HUFF FARMINGTON MO | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma, Nasopharynx | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH 12 yrs | |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) 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. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown | | | | 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 1948 to 6-19-60 and last saw her alive on 6-19-60 Death occurred at 7:30 P m on the date stated above, and to the best of my knowledge, from the causes stated. | | | | | | | | | |
| 22. SIGNATURE Alan G. Karkut M.D. (Degree or title) | | | | | 22b. ADDRESS Farmington, Mo. | | | 22c. DATE SIGNED 6-28-60 | |
| 23a. BURIAL, CREMATION, REQUIAL (Specify) BURIAL | | 23b. DATE JUNE 22/60 | | 23c. NAME OF CEMETERY OR CREMATORY HILLVIEW MEMORIAL | | 23d. LOCATION (City, town, or county) NEAR FARMINGTON | | STATE MO. | |
| 24. FUNERAL DIRECTOR C.H. COZEAN FARMINGTON MO. | | | | 25. DATE RECD. BY LOCAL REG. June 28 1960 | | 26. REGISTRAR'S SIGNATURE Esther Rudloff | | | |

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 _____

Licensed Embalmer No. 0408

P. O. Address Farmington

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