

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS. OCT 18 1960

53

Primary Registration District No. 3010

Registrar's No. 407

STATE FILE NUMBER 60-037694

INDEXED

1. PLACE OF DEATH a. COUNTY <b>Cape Girardeau</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo.</b> b. COUNTY <b>Cape Girardeau</b>				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Cape Girardeau</b>		Length of stay in lb <b>38 Yrs</b>		c. CITY OR TOWN <b>Cape Girardeau</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>Southeast Mo. Hospital</b>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <b>837 N. Main</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Manzona M.W Huffman</b>				4. DATE OF DEATH Month Day Year <b>Oct 13 1960</b>				
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <b>Oct 22 1875</b>	9. AGE (last birthday) <b>84</b>	IF UNDER 1 YEAR Months <b>11</b> Days <b>21</b>	IF UNDER 24 HR Hours <b></b> Min. <b></b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Carpenter</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Southeast Hospital</b>		11. BIRTHPLACE (City and state or country) <b>Whitewater Mo.</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A</b>	
13a. FATHER'S NAME <b>Henry Huffman</b>			13b. MOTHER'S MAIDEN NAME <b>Roxana Ramsey</b>			14. NAME OF HUSBAND OR WIFE <b>Deceased</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>			16. SOCIAL SECURITY NO. <b>UNKNOWN</b>		17. INFORMANT Address <b>Mrs Norman Poston Cape Gir Mo.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic heart disease</b>							INTERVAL BETWEEN ONSET AND DEATH <b>?</b>	
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) <b>abdominal aortic aneurysm</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			
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.) <b>not known</b>				
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 <b>10-6-60</b> to <b>10-13-60</b> and last saw him alive on <b>10-12-60</b> Death occurred at <b>10-30 A. M.</b> on the date stated above, and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE (Degree or title) <b>Charles F. Williams M.D.</b>				22b. ADDRESS <b>14 Froadway, Cape Girardeau, Mo.</b>			22c. DATE SIGNED <b>10-15-60</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>Oct 16 1960</b>	23c. NAME OF CEMETERY-OR CREMATORY <b>Lorimier</b>		23d. LOCATION (City, town, or county) (State) <b>Cape Gir Mo.</b>			
24. FUNERAL DIRECTOR <b>Prinkopf Howell . Cape Gir Mo.</b>				25. DATE RECD. BY LOCAL REG. <b>Oct. 15, 1960</b>		26. REGISTRAR'S SIGNATURE <b>Gene Kasten</b>		

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

