

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS/NOV 9 1960
 Registration District No. 317

Primary Registration District No. 547

Registrar's No. 3096

-60-040540
 STATE FILE NUMBER

| | | | | | | | | | |
|--|--|---|--|---|---|--|---|--------------------|--|
| 1. PLACE OF DEATH a. COUNTY St. Louis County | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Franklin | | | | | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN RICHMOND MO. HTS. | | Length of stay in 1b 20 days | | c. CITY OR TOWN St. Clair, Mo. | | Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | | | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Mary Hospital | | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | d. STREET ADDRESS (If outside, give location) St. Clair, Mo. R#1 | | Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | |
| 3. NAME OF DECEASED (Type or print) First Robert Middle Lee Last Huff | | | | 4. DATE OF DEATH Month Oct. Day 24 , Year 1960 | | | | | |
| 5. SEX Male | 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 Mar. 22, 1929 | 9. AGE (last birthday) 31 | IF UNDER 1 YEAR Months 7 Days 2 | IF UNDER 24 HR Hours Min. | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Brick Layer | | | 10b. KIND OF BUSINESS OR INDUSTRY General Brick Layer | | 11. BIRTHPLACE (City and state or country) St. Clair, Mo. | | 12. CITIZEN OF WHAT COUNTRY U. S. A. | | |
| 13a. FATHER'S NAME Gillman Huff | | | 13b. MOTHER'S MAIDEN NAME Lottie Erbes | | | 14. NAME OF HUSBAND OR WIFE Janet Huff, St. Clair, Mo. | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes 1951 to 1955 | | | 16. SOCIAL SECURITY NO. 498-32-3027 | | 17. INFORMANT Janet Huff, St. Clair, Mo. | | | Address Mo. | |
| 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) Head Injury | | | | | | | | | |
| DUE TO (b) Fall | | | | | | | | | |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (c) Brain Edema | | | | | | | | | |
| 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 | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20a. ACCIDENT <input checked="" 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.) FALL OCCURRED AT 7450 HAMPTON WHILE AT WORK | | | | | | | |
| 20c. TIME OF INJURY 11:45 a.m. | | Month, Day, Year 10-4-60 | | | | | | | |
| 20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" 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 10-5-60 to 10-24-60 and last saw her/him alive on 10-24-60 Death occurred at 5 PM m on the date stated above, and to the best of my knowledge, from the causes stated. | | | | | | | | | |
| 22a. SIGNATURE Frank A. Palazzo MD (Dr. or title) | | | 22b. ADDRESS 4161 Lindell Blvd. | | | 22c. DATE SIGNED 10-25-60 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL | | 23b. DATE Oct. 27, 1960 | 23c. NAME OF CEMETERY OR CREMATORY Bethel Cemetery | | 23d. LOCATION (City, town, or county) Lone Dell, Missouri | | (State) | | |
| 24. FUNERAL DIRECTOR Sherman W. Mitchell | | ADDRESS St. Clair, Mo. | | 25. DATE RECD. BY LOCAL REG. 10-25-60 | | 26. REGISTRAR'S SIGNATURE John C. McCarthy | | | |

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

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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 Elmer K. Sadew

Licensed Embalmer No. 4071

P. O. Address St Louis

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.