

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-040881

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

STATE FILE NUMBER

Registration District No. 143 Primary Registration District No. 5336 Registrar's No. 57

AMENDED

FILED DEC 1-9-1961

1. PLACE OF DEATH a. COUNTY <u>Howell</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Howell</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Hallsberry T.</u>		c. CITY OR TOWN <u>Mountain View</u>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Home</u>		d. STREET ADDRESS (If outside, give location) <u>Rural Route 1</u>	

3. NAME OF DECEASED (Type or print) First <u>Thomas</u> Middle <u>Franklin</u> Last <u>Huff</u>			4. DATE OF DEATH Month <u>November</u> Day <u>22</u> Year <u>1961</u>			
5. SEX <u>M.</u>	6. COLOR OR RACE <u>W.</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>2/2/12</u>	9. AGE (last birthday) <u>49</u>	IF UNDER 1 YEAR IF UNDER 24 HR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Gen Smith</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <u>Trask, Mo.</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>
13a. FATHER'S NAME <u>W. A. Huff</u>		13b. MOTHER'S MAIDEN NAME <u>Mary F. Fry</u>		14. NAME OF HUSBAND OR WIFE <u>Mabel Huff</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, pp. or unknown) (If yes, give war or dates of service) <u>No</u>			17. INFORMANT <u>Mabel Huff</u> Address <u>Mtn. View, Mo. Rt. 1</u>			

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>Carcinoma of lung</u>		INTERVAL BETWEEN ONSET AND DEATH
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 type="checkbox"/> No <input type="checkbox"/> Unknown	
---	--	--	--

19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input 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 <u> </u> a.m. / p.m. Month, Day, Year <u> </u>			

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 July 1961 to Nov 1961 and last saw her/him alive on Nov. 2, 1961
Death occurred at Nov 22, 1961 on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <u>M.C. Walton M.D.</u>	22b. ADDRESS <u>Mt. View, Mo.</u>	22c. DATE SIGNED <u>12-8-61</u>
---	--------------------------------------	------------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>11/25/1961</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Walker Chapel Cem.</u>	23d. LOCATION (City, town, or county) (State) <u>Trask Missouri</u>
--	--------------------------------	---	--

24. FUNERAL DIRECTOR <u>Duncan Funeral Home</u>	ADDRESS <u>Mtn. View, Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>12-9-61</u>	26. REGISTRAR'S SIGNATURE <u>Laura Mitchell</u>
--	----------------------------------	--	--

DATE AMENDED

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

ITEM NO. SHOULD READ

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Charles D. Cartain

Licensed Embalmer No. 5107

P. O. Address Mt. Union

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.