

**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

Do not use this space.

NOV 24 1930

1. PLACE OF DEATH

County Henry Registration District No. 358
Township Shaynee Primary Registration District No. 5502
City Cheltenham (No. _____) St. _____ Ward _____

32715

File No. _____
Registered No. N

2. FULL NAME

James M. Huff
(a) Residence No. _____ St. _____ Ward _____
(Usual place of abode) (If nonresident, give city or town and State)
Length of residence in city or town where death occurred 70 yrs. — mos. — ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) widowed
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Susan Huff
6. DATE OF BIRTH (MONTH, DAY AND YEAR) Sept 4-1848
7. AGE YEARS MONTHS DAYS IF LESS than 1 day, _____ hrs. or _____ min.
82 1 1

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer) _____
(c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) Marshall
(STATE OR COUNTRY) Mo

10. NAME OF FATHER B. Huff
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Dont know
12. MAIDEN NAME OF MOTHER Dont know
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Dont know

14. INFORMANT Walter Beatty
(Address) Cheltenham Mo

15. FILED 10/13 1930 E. G. Hibler
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 10-5 1930
17. I HEREBY CERTIFY, That I attended deceased from _____, 1930, to Oct 5, 1930, that I last saw h. in alive on Sept 15, 1930, and that death occurred, on the date stated above, at 11:30 P.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Chronic nephritis
131
(duration) 2 yrs. mos. ds.

CONTRIBUTORY (SECONDARY) _____ (duration) _____ yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED _____
IF NOT AT PLACE OF DEATH _____

19. DID AN OPERATION PRECEDE DEATH? no DATE OF _____

20. WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS?
(Signed) E. S. Walker, M. D.

10-5, 1930 (Address) Clinton Mo

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) Whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL DATE OF BURIAL

Cassville 10/8 1930

20. UNDERTAKER ADDRESS
Sunny Coast Cheltenham Mo

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

