

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

65-044492

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 163 Primary Registration District No. 5593 Registrar's No. 103

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

FILED DEC 14 1965

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Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

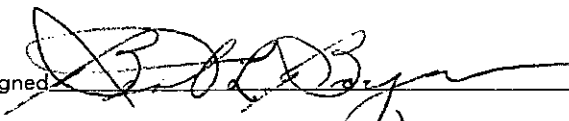
1. PLACE OF DEATH a. COUNTY <u>Jefferson</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) e. STATE <u>Mo.</u> b. COUNTY <u>St. Francois</u>	
b. CITY (If outside corporate limits, give TOWNSHIP) OR TOWN <u>Plattin</u> Length of stay in 1b <u>10 mo.</u>		c. CITY OR TOWN <u>Leadwood</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>BURT MANOR NURSING Home</u> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>BELLE HUFF</u>			4. DATE OF DEATH Month Day Year <u>Dec. 7, 1965</u>
5. SEX <u>Female</u>	6. COLOR OR RACE <u>WHITE</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>4-28-1889</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (last birthday) <u>76</u> IF UNDER 1 YEAR Months Days IF UNDER 24 HR. Hours Min.
13a. FATHER'S NAME <u>William T. Gilliam</u>		11. BIRTHPLACE (City and state or country) <u>Quaker, Mo.</u> 12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13b. MOTHER'S MAIDEN NAME <u>ZINA Bryan</u>		14. NAME OF HUSBAND OR WIFE <u>Clardy Huff</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u> 17. INFORMANT Address <u>Dorothy Johnson, Leadwood, Mo.</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>Arteriosclerotic heart disease</u> INTERVAL BETWEEN ONSET AND DEATH <u>1 year +</u> DUE TO (b) <u>Generalized arteriosclerosis</u> <u>1 year +</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Cerebral accident with right hemiparesis, pleuro-pneumonia, one year.</u> 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.)
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 <u>Feb 27, 1965</u> to <u>Dec 7, 1965</u> and last saw her alive on <u>Dec 7, 1965</u> Death occurred at <u>10:15 P.m.</u> m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>Thomas A. Donnell M.D.</u>		22b. ADDRESS <u>Desoto, Mo.</u>	22c. DATE SIGNED <u>12-9-65</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>12-11-1965</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Leadwood Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Leadwood, Missouri</u>
24. FUNERAL DIRECTOR ADDRESS <u>Bert L. Boyer, Leadwood, Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>12-11-1965</u>	26. REGISTRAR'S SIGNATURE <u>Marie Farris</u>

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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 me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed 

Licensed Embalmer No. 3441

P. O. Address Hadwood, Mo.

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.

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