Huckstep

DEPARTMENT OF PUBLIC HEALTH AND WELFARE — MISSOURI DIVISION OF HEALTH
(PHYSICIAN OR CORONER)

FILED NOV 4 1970

124

STATE FILE NUMBER 70 0042332

CERTIFICATE OF DEATH

DO NOT WRITE ON THIS STUB

VS 300 Rev. 1/70

Registration District No. 316 Primary Registration District No. 3068 Registrar's No. 493

9.	1
10a.	75
10b.	
11.	0
12.	1
13.	4123
14.	
15.	4
16.	
17.	
18.	0
19. CREDITS	
20.	1-0

4 0945

5. 90

DECEASED

USUAL RESIDENCE WHERE DECEASED LIVED. IF DEATH OCCURRED IN INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION.

6. 0945

PARENTS

CAUSE

CERTIFIER

BURIAL

1. DECEASED—NAME (FIRST, MIDDLE, LAST): DELLA MAE WAUD
2. SEX: FEMALE
3. DATE OF DEATH (MONTH, DAY, YEAR): OCT. 25, 1970
4. RACE (WHITE, NEGRO, AMERICAN INDIAN, ETC.): WHITE
5a. AGE—LAST BIRTHDAY (YEARS): 75
5b. UNDER 1 YEAR—MOS.: DAYS:
5c. UNDER 1 DAY—HOURS: MIN.:
6. DATE OF BIRTH (MONTH, DAY, YEAR): AUG. 22, 1895
7a. COUNTY OF DEATH: ST. FRANCOIS
7b. CITY, TOWN, OR LOCATION OF DEATH: FARMINGTON
7c. INSIDE CITY LIMITS (SPECIFY YES OR NO): YES
7d. HOSPITAL OR OTHER INSTITUTION—NAME (IF NOT IN EITHER, GIVE STREET AND NUMBER): 316 POTOSI ST.
8. STATE OF BIRTH (IF NOT IN U.S.A., NAME COUNTRY): MISSOURI
9. CITIZEN OF WHAT COUNTRY: U.S.A.
10. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (SPECIFY): MARRIED
11. SURVIVING SPOUSE (IF WIFE, GIVE MAIDEN NAME): HOWARD M. WAUD
12. SOCIAL SECURITY NUMBER: 553-18-8418B
13a. USUAL OCCUPATION (GIVE KIND OF WORK DONE DURING MOST OF WORKING LIFE, EVEN IF RETIRED): HOUSEWIFE
13b. KIND OF BUSINESS OR INDUSTRY:
14a. RESIDENCE—STATE: MISSOURI
14b. COUNTY: ST. FRANCOIS
14c. CITY, TOWN, OR LOCATION: FARMINGTON
14d. INSIDE CITY LIMITS (SPECIFY YES OR NO): YES
14e. STREET AND NUMBER: 316 POTOSI

PARENTS

15. FATHER—NAME (FIRST, MIDDLE, LAST): THOMAS MILTON CUNNINGHAM
16. MOTHER—MAIDEN NAME (FIRST, MIDDLE, LAST): JESSE ADALINDA ORTEN

17a. INFORMANT—NAME: HOWARD M. WAUD
17b. MAILING ADDRESS (STREET OR R.F.D. NO., CITY OR TOWN, STATE, ZIP): 316. POTOSI ST. FARMINGTON, MO.

CAUSE

PART I. DEATH WAS CAUSED BY: (ENTER ONLY ONE CAUSE PER LINE FOR (a), (b), AND (c))

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
18. IMMEDIATE CAUSE (a)	Arteriosclerotic Heart Disease	2 years
DUE TO, OR AS A CONSEQUENCE OF: (b)		
CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST — DUE TO, OR AS A CONSEQUENCE OF: (c)		

PART II. OTHER SIGNIFICANT CONDITIONS: CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO CAUSE GIVEN IN PART I (a)

19a. AUTOPSY (YES OR NO): NO
19b. IF YES WERE FINDINGS CONSIDERED IN DETERMINING CAUSE OF DEATH:

20a. ACCIDENT, SUICIDE, HOMICIDE, OR UNDETERMINED (SPECIFY)	20b. DATE OF INJURY (MONTH, DAY, YEAR)	20c. HOUR	20d. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN PART I OR PART II, ITEM 18)
		M.	

20e. INJURY AT WORK (SPECIFY YES OR NO)	20f. PLACE OF INJURY AT HOME, FARM, STREET, FACTORY, OFFICE BLDG., ETC. (SPECIFY)	20g. LOCATION (STREET OR R.F.D. NO., CITY OR TOWN, STATE)	IF DECEASED WAS FEMALE WAS THERE A PREGNANCY IN LAST 90 DAYS 20h. ☐ YES ☒ NO ☐ UNK

CERTIFIER

CERTIFICATION—PHYSICIAN: I ATTENDED THE 21a. DECEASED FROM Nov 1967 TO 21b. 10-25-70 AND LAST SAW HIM/HER ALIVE ON 21c. 10 25 1970 I DID/DID NOT VIEW THE BODY AFTER DEATH. 21d. DEATH OCCURRED (HOUR) 21e. PM AT THE PLACE, ON THE DATE, AND, TO THE BEST OF MY KNOWLEDGE, DUE TO THE CAUSE(S) STATED.

CERTIFICATION—MEDICAL EXAMINER OR CORONER: ON THE BASIS OF THE EXAMINATION OF THE BODY AND/OR THE INVESTIGATION, IN MY OPINION, DEATH OCCURRED ON THE DATE AND DUE TO THE CAUSE(S) STATED. 22a. HOUR OF DEATH M. THE DECEDENT WAS PRONOUNCED DEAD (MONTH, DAY, YEAR, HOUR) 22b. M.

23a. CERTIFIER—NAME (TYPE OR PRINT): R.A. HUCKSTEP, M.D.
23b. SIGNATURE: R. A. Huckstep M.D.
23c. DATE SIGNED (MONTH, DAY, YEAR): 10-26-70
23d. MAILING ADDRESS—CERTIFIER (STREET OR R.F.D. NO., CITY OR TOWN, STATE): FARMINGTON, MO. 63640

BURIAL

24a. BURIAL, CREMATION, REMOVAL (SPECIFY): BURIAL
24b. CEMETERY OR CREMATORY—NAME: THREE RIVERS CEM.
24c. LOCATION (CITY OR TOWN, STATE): FARMINGTON RT. 2, MO.
24d. DATE (MONTH, DAY, YEAR): OCT. 29, 1970
25a. FUNERAL HOME—NAME AND ADDRESS (STREET OR R.F.D. NO., CITY OR TOWN, STATE, ZIP): COZEAN FUNERAL HOME 217 W. COLUMBIA FARMINGTON, MO.
25b. FUNERAL DIRECTOR—SIGNATURE: C.H. Cozean
26a. REGISTRAR—SIGNATURE: Esther Mathews
26b. DATE RECEIVED BY LOCAL REGISTRAR: Oct. 26, 1970

Type or print in PERMANENT BLACK INK. See handbook for instructions.

NOV 6 1970

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 O A Cozean

Licensed Embalmer No. 4084

P. O. Address Farmington 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.