

SEP 25 1940

Registration District No.

799

Primary Registration District No.

4479

Registrar's No.

42

1. PLACE OF DEATH:

(a) County Saline
(b) City or town Slater
(c) Name of hospital or institution: Home 563 Leroy St. 2
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution No
(Specify whether
In this community. Six months
years, months or days)

3. (a) PRINT FULL NAME Anthony Huff 100

8. (b) If veteran, name war A 8. (c) Social Security No. A

4. Sex Male 5. Color or race Wh 6. (a) Single, widowed, married, divorced married

6. (b) Name of husband or wife Nellie Huff 6. (c) Age of husband or wife if alive 70 years

7. Birth date of deceased March 11 1865
(Month) (Day) (Year)

8. AGE: Years 75 Months 5 Days 3 If less than one day hr. min.

9. Birthplace Saline County Mo.
(City, town, or county) (State or foreign country)

10. Usual occupation Farmer

11. Industry or business Retired

12. Name Anthony C. Huff

13. Birthplace Don't Know 9
(City, town, or county) (State or foreign country)

14. Maiden name Sarah Goodman

15. Birthplace Don't Know 9
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Eubert Huff

(b) Address Slater Mo.

17. (a) Burial (b) Date thereof 8 17 1940
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Slater Mo.

18. (a) Signature of funeral director Will Bros. 799

(b) Address Slater Mo.

19. (a) Aug 16 (b) W. M. Tuttle
(Date received by local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County _____
(c) City or town Slater
(If outside city or town limits, write "RURAL")
(d) Street No. 563 Leroy
(If rural, give location)
(e) If foreign born, how long in U. S. A.? A years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 15th
year 1940 hour 11 minute 00 A.M.

21. I hereby certify that I attended the deceased from Need Inquest to Aug 15, 1940
that I last saw h alive on _____, 19____
and that death occurred on the date and hour stated above.

Immediate cause of death Hanging by the neck from a tree. and with suicidal intent
Due to _____
Due to _____

Other conditions (Include pregnancy within 3 months of death) _____

Major findings: Of operations 16
Of autopsy None

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) suicide
(b) Date of occurrence _____
(c) Where did injury occur? _____ (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? Home

While at work? no (Specify type of place) (e) Means of injury _____

23. Signature B. C. Bradshaw D. or other 5
Address Arrow Rock Date signed 8-15-1940

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE 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.

10-11-30 I X1931

RECEIVED
District Health Officer No. 8,
District File Number
Date Filed 9-11-40

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

Edgar Moore

Registered Apprentice No. **230**

working under my personal supervision.

Signed **A. C. Hill**

Licensed Embalmer No. **3090**

P. O. Address

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 this body is not embalmed, above space should be left blank.