

AUG 15 1935

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

Do not use this space.

1. PLACE OF DEATH
 County Grundy Registration District No. 329 File No. 22813
 Township Marion Primary Registration District No. 54 54a Registered No.
 City Galt (No. _____ St. _____ Ward _____)

2. FULL NAME Hiram P. Huffstutter
 (a) Residence, No. _____ St. _____ Ward _____ (If nonresident, give city or town and State)
 Length of residence in city or town where death occurred 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 Single
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____
 6. DATE OF BIRTH (MONTH, DAY AND YEAR) Jan. 18, 1867
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
68 6 11
 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) _____ (STATE OR COUNTRY) Indiana

10. NAME OF FATHER John Huffstutter
 11. BIRTHPLACE OF FATHER (CITY OR TOWN) _____ (STATE OR COUNTRY) Va.
 12. MAIDEN NAME OF MOTHER Margaret Harry
 13. BIRTHPLACE OF MOTHER (CITY OR TOWN) _____ (STATE OR COUNTRY) Scotland

14. INFORMANT Mrs. Mary Kincaid (Address) Galt Mo
 15. FILED 8-1-35 J. G. Humphreys REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) July 29 1935
 17. I HEREBY CERTIFY, That I attended deceased from July 21, 1935, to July 29, 1935 that I last saw him alive on July 22, 1935, and that death occurred, on the date stated above, at 1:32 A. m.
 THE CAUSE OF DEATH* WAS AS FOLLOWS:
Diabetes Mellitus
 (duration) _____ yrs. _____ mos. _____ ds.
 CONTRIBUTORY (SECONDARY) _____ (duration) _____ yrs. _____ mos. _____ ds.
 18. WHERE WAS DISEASE CONTRACTED _____
 IF NOT AT PLACE OF DEATH _____
 DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____
 WAS THERE AN AUTOPSY? _____
 WHAT TEST CONFIRMED DIAGNOSIS? Sym
 (Signed) H. E. Brown M. D.
7-29-1935 (Address) Galt 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 Rural Dale Cem. DATE OF BURIAL July 30 1935
 20. UNDERTAKER Raymondson ADDRESS Galt Mo

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.

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