

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

Do not use this space.

1. PLACE OF DEATH

County.....
Township.....
City..... *St Louis*

Registration District No. **791**
Primary Registration District No. **1003**

File No. **6559**
Registered No. **1402**
St. _____ Ward _____

2. FULL NAME

(a) Residence, No. *R118 nebraska* St., *15* Ward.
(Usual place of abode)

(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 (write the word) *widower*

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) *Oct. 27, 1857*

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, hrs. or min.
	<i>76.</i>	<i>3</i>	<i>10.</i>	

OCCUPATION 8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. *Printer*
9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.
10. Date deceased last worked at this occupation (month and year) 11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *St Louis MO.*

MOTHER: 13. NAME *John Huber*

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Bohemia*

15. MAIDEN NAME *Rose Hozek*

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Bohemia*

17. INFORMANT (ADDRESS) *Robt Huber 2118 nebraska ave*

18. BURIAL, CREMATION, OR REMOVAL PLACE DATE *St Peter's Chh. Feb 10, 1934*

19. UNDERTAKER (ADDRESS) *Jhos Kuttis 2906 Graves*

20. FILED *FFM - 6 1537* 19 *34* *J Brebeck* Registrar.

2 MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *July 7, 1934*

22. I HEREBY CERTIFY, That I attended deceased from *Jan 23, 1934, to July 7, 1934*

I last saw him alive on *July 7, 1934*. Death is said to have occurred on the date stated above, at *4:30 P.M.*

The principal cause of death and related causes of importance were as follows:

apoplexy
82A
102
High Blood Pressure

Name of operation _____ Date of _____
What test confirmed diagnosis? *Paralysis* Was there an autopsy? *no*

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? _____ Date of injury _____, 19____
Where did injury occur? _____ (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury _____
Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? _____
If so, specify _____
(Signed) *J Marshall* M. D.
(Address) *433 Metropolitan Bldg*

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CERTIFICATE OF DEATH**

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County.....
Township.....
City.....

Registration District No. 791
Primary Registration District No. 1003

File No. 6559
Registered No. 1402
St. Ward

2. FULL NAME

Charles J Huber

(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 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX m 4. COLOR OR RACE w 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED w (write the word)

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Oct 27 - 1857

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
76 3 10

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.
9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.
10. Date deceased last worked at this occupation (month and year).....
11. Total time (years) spent in this occupation.....

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

13. NAME

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

15. MAIDEN NAME

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL PLACE DATE 19

19. UNDERTAKER (ADDRESS)

20. FILED 5-29-34 J. J. Bredack Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Feb 7, 1934

22. I HEREBY CERTIFY, That I attended deceased from to 19.....
I last saw h..... alive on....., 19..... Death is said to have occurred on the above, at..... m.

The principal cause of death and related causes of importance were as follows:
a proplexy - cerebral Date of onset

Other contributory causes of importance:

Name of operation..... Date of.....
What test confirmed diagnosis?..... Was there an autopsy?.....

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide?..... Date of injury....., 19.....
Where did injury occur?..... (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury.....
Nature of injury.....

24. Was disease or injury in any way related to occupation of deceased?.....
If so, specify.....
(Signed)....., M. D.
(Address).....

SUPPLEMENTARY

REGISTRARS SHALL NOT FILE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

6559-8