

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

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

10212  
Do not use this space.

1. PLACE OF DEATH  
(a) County Buchanan Registration District No. 2  
(b) Township 3 Primary Registration District No. 1001 Registered No. 292  
(c) City St. Joseph (d) Street No. State Hospital # 2. St.  
(If death occurred in Hospital or Institution, write its name instead of street and number)  
(e) Length of residence in city or town where death occurred 68 yrs. (f) How long in U. S., if of foreign birth? 72 yrs. - mos. - ds.  
2. PRINT FULL NAME  
(a) Residence, No. 156 J. Gottlieb Huebner St. Joseph, Mo.  
(Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS				
3. SEX male	4. COLOR OR RACE white	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) wid.		
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Rose (Nick)				
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) June 15, 1850				
7. AGE	YEARS 89	MONTHS 8	DAYS 26	If LESS than 1 day, ..... hrs. or ..... min.
OCCUPATION	8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. hairyman			
	9. Industry or business in which work was done, as saw mill, bank, etc. retired			
	10. Date deceased last worked at this occupation (month and year) 1915 11. Total time (years) spent in this occupation. 50 Yrs			
12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Stuttgart Germany				
FATHER	13. NAME Unknown			
	14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Unknown Germany			
MOTHER	15. MAIDEN NAME Unknown			
	16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Unknown Germany			
17. INFORMANT (ADDRESS) W. H. Huebner, 3006 Angeline St. Gas. Mo.				
18. BURIAL, CREMATION, OR REMOVAL Mt. Olivet Cemetery PLACE St. Joseph, Mo. DATE Mar. 14, 1940				
19. FUNERAL DIRECTOR (NAME) (ADDRESS) H. O. Sidenfaden & Son 1802 Union Str. St. Joseph, Mo.				
20. FILED March 12, 1940 H. Nestlebach Local Registrar				

MEDICAL CERTIFICATE OF DEATH	
21. DATE OF DEATH (MONTH, DAY, AND YEAR) Mar. 11, 1940	
22. I HEREBY CERTIFY, That I attended deceased from July 23, 1938, to Mar. 11, 1940 I last saw him alive on Mar. 11, 1940. Death is said to have occurred on the date stated above, at 6 P. M. The principal cause of death and related causes of importance were as follows: Arteriosclerosis 150 W Other contributory causes of importance: fracture of l. femur (at neck) 3/8/40 l. humerus radius & ulna Name of operation immobilizing Date of (C. S. I.) What test confirmed diagnosis? Clinical Was there an autopsy? no	
23. If death was due to external causes (violence), fill in also the following: Accident, suicide, or homicide? accident Date of injury 3/8, 1940 Where did injury occur? Mt. P. I. State Hospital # 2 (Specify city or town, county, and State) Specify whether injury occurred in industry, in home, or in public place. Manner of injury fell on concrete floor Nature of injury all above	
24. Was disease or injury in any way related to occupation of deceased? no If so, specify..... (Signed) T. G. Dell, M. D. (Address) St. Joseph, Mo.	

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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.....

....., Registered Apprentice No.....  
working under my personal supervision.

Signed Robert P. Clarkson

Licensed Embalmer No. 4028

P. O. Address St. Joseph, Mo.

**Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to conform with the above constitutes grounds for revocation of license.)**

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

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 10212

Registration District No. 85

Primary Registration District No. 1001

Registrar's No. 292

1. PLACE OF DEATH:

(a) County Buchanan  
(b) City or town St. Joseph  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_  
In this community 12 years, months or days (Specify whether in)

3. (a) PRINT FULL NAME Jonathan Kottlieb Heubner  
3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex m 5. Color or race w 6. (a) Single, widowed, married, divorced wid  
6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband, or wife, if alive \_\_\_\_\_ year  
7. Birth date of deceased: (Month) (Day) (Year)

8. AGE: Years 89 Months 8 Days 26 If less than one day hr. min.

9. Birthplace: (City, town, or county) (State or foreign country)

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

12. Name \_\_\_\_\_

13. Birthplace: (City, town, or county) (State or foreign country)

14. Maiden name \_\_\_\_\_

15. Birthplace: (City, town, or county) (State or foreign country)

16. (a) Informant \_\_\_\_\_

(b) Address \_\_\_\_\_

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

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

19. (a) 12-27-40 (b) [Signature]  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Mar day 11  
year 1940 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_;  
that I last saw h\_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_,  
and that death occurred on the date and hour stated above.

Immediate cause of death \_\_\_\_\_

Due to \_\_\_\_\_

Due to \_\_\_\_\_

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

Major findings: Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) \_\_\_\_\_

(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?

While at work? (Specify type of place) (c) Means of injury \_\_\_\_\_

23. Signature \_\_\_\_\_ (M. D. or other) \_\_\_\_\_

Address \_\_\_\_\_ Date signed \_\_\_\_\_

SUPPLEMENTAL COPY

MOTHER FATHER

S-10212 A40