

Registration District No. 784

Primary Registration District No. 101

Registrar's No. 1615

1. PLACE OF DEATH:

(a) County St. Louis
 (b) City or town St. Louis, Mo. Clayton
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
St. Louis County Hospital
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 13 days
 In this community 23 Years
 (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Louis
 (c) City or town St. Louis
 (If outside city or town limits, write "RURAL")
 (d) Street No. 5379a Cabanne
 (If rural, give location)
 (e) If foreign born, how long in U. S. A.? 23 Years years.

3. (a) PRINT FULL NAME SAMUEL HUBERT 163

3. (b) If veteran, name war No 3. (c) Social Security No. No

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

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased April 29 1917
 (Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>23</u>	<u>3</u>	<u>24</u>	hr. min.

9. Birthplace St. Louis Mo.
 (City, town, or county) (State or foreign country)

10. Usual occupation Decorator

11. Industry or business _____

MOTHER FATHER { 12. Name Joseph Hubert

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

14. Maiden name Josephine Epstein

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

16. (a) Informant Josephine Huberts

(b) Address 5379a Cabanne

17. (a) Burial (b) Date thereof Aug. 25-40
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mount Olive

18. (a) Signature of funeral director O. Deschandler

(b) Address 4469 Washington

19. (a) AUG 25 1940 (b) J. W. Meyer
 (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 23
 year 1940 hour 10 minutes 10 a. M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;

that I last saw him alive on _____, 19____; and that death occurred on the date and hour stated above.

Immediate cause of death Auto accident while riding as a passenger in an automobile on a public highway Duration 8/11/40
 Due to Slip & road build

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

Major findings: Of operations 210 mm PHYSICIAN

Of autopsy Several pieces Generalized peritonitis 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) Accident
 (b) Date of occurrence Aug 11/40
 (c) Where did injury occur? St. Louis County
 (City or town) (County) (State)
 (d) Did injury occur in or about home, on farm, in industrial place, in public place?
Public Place (Specify type of place)

While at work? No (Specify type of place) (a) Means of injury not known

23. Signature John L. Conroy (M. D. or other) MD
 Address Conroy Date signed 8/24/40

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

210 m
95

1901

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.....

myself

Registered Apprentice No.....

working under my personal supervision.

Signed.....

W B Crenshaw

Licensed Embalmer No.....

3669

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, fact should be so stated above.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

State File No. 29574
Registrar's No. 1615

Registration District No. 784

Primary Registration District No. 101

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF BIRTH:

(a) County St. Louis

(b) City or town.....
(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.....
(Specify whether years, months or days)

3. (a) PRINT FULL NAME Samuel Hubert

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. 8

6. (b) Name of husband or wife.....

6. (c) Age of husband, or wife, if alive..... years

7. Birth date of deceased (Month) (Day) (Year)

8. AGE: Years 23 Months 3 Days 24 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) (b) Date thereof..... (Month) (Day) (Year)

(c) Place: burial or cremation.....

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

(b) Address.....

19. (a) (b) (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 Aug day 23 year 1940 hour..... minute..... M.

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

Immediate cause of death Auto accident while riding as a passenger in an automobile over a public highway. Due to struck Rock boulder on Curve (Stationary)

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

Major findings: Generalized peritonitis

Of autopsy.....

PHYSICIAN J. P. Dr.
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)..... acc

(b) Date of occurrence Aug 11, 1940

(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?
Public Place
(Specify type of place)

While at work?..... (e) Means of injury.....

23. Signature..... (M. D. or other).....
Address..... Date signed.....



