

FD JAN 15 1947 91 1
Registration District No.

Primary Registration District No. 1003

1. PLACE OF DEATH:

(a) County St. Louis mo.
(b) City or town St. Louis mo.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Firmin DeLoze Hosp.
(If not in hospital or institution, write street number or location) 10
(d) Length of stay: In hospital or institution _____ (Specify whether _____)
In this community one week
years, months or days

3. (a) PRINT FULL NAME Louise E. Hubbell

3. (b) If veteran, name war None 3. (c) Social Security No. None

4. Sex male 5. Color or race White
6. (a) Single, widowed, married, divorced married
6. (b) Name of husband or wife Emma L. Hubbell
6. (c) Age of husband or wife if alive 60 years
7. Birth date of deceased Nov. 7th 1874
(Month) (Day) (Year)

8. AGE: Years 66 Months _____ Days 2 If less than one day hr. _____ min. _____

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

10. Usual occupation machinist

11. Industry or business 9

MOTHER FATHER { 12. Name unknown 7
13. Birthplace " 1
(City, town, or county) (State or foreign country)

MOTHER FATHER { 14. Maiden name unknown
15. Birthplace "
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Rev. C. E. Shumate

(b) Address 4446 Washington Pl.

17. (a) Burial (b) Date thereof Dec 13/40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Oak Hill Cemetery

18. (a) Signature of funeral director Chas. A. Bull

(b) Address 4457 Washington Pl.

19. (a) DEC 11 1940 (b) J. F. Bedeck
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County _____
(c) City or town St. Louis (If outside city or town limits, write "RURAL") N.R.
(d) Street No. 4374 Clayton Ave.
(If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 12-9-40 day _____
year _____ hour 11²⁵ P.M. minute _____ M.

21. I hereby certify that I attended the deceased from 11-30-40
_____, 19____, to 12-9-40, 19____;
that I last saw him alive on 12-9-40, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death aplastic anemia
Duration _____

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

PHYSICIAN
Major findings: _____
Of operations _____
Of autopsy Enlarged spleen
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) Means of injury 1
23. Signature Geo. J. Flynn (M. D. or other) _____
Address Firmin DeLoze Hosp. Date signed Dec 11-40

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.

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.....

John Ketter

Licensed Embalmer No.....

3880

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.