

FILED MAY 15 1944

State File No. _____

Registration District No. _____

Primary Registration District No. **1003**

Registrar's No. **4263**

1. PLACE OF DEATH:

(a) County _____
(b) City or town **St. Louis**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Geitner Home, 5000 S. Broadway
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether
in this community _____ years, months or days)

2. USUAL RESIDENCE OF DECEASED:

Missouri
(a) State _____ (b) County _____
(c) City or town **St. Louis**
(If outside city or town limits, write "RURAL")
(d) Street No. **Geitner Home, 5000 S. Broadway**
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME **Deana Huebner**

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

4. Sex **Female** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **Widow**
6. (b) Name of husband or wife **George** 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased **Dec. 21 1851**
(Month) (Day) (Year)

8. AGE: Years **92** Months **4** Days **16** If less than one day _____ hr. _____ min.

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 12. Name **Bode**
13. Birthplace **Germany**
(City, town, or county) (State or foreign country)
14. Maiden name **Unknown**
15. Birthplace **Germany**
(City, town, or county) (State or foreign country)

16. (a) Informant **R. W. Stuckenberg**
(b) Address **3625 South Grand Boul.**

17. (a) **Cremation** (b) Date thereof **May 10, 1944**
(Burial, cremation, or removal) (Month) (Day) (Year)
Valhalla Cemetery, Creve Coeur

(c) Place: burial or cremation _____
18. (a) Signature of funeral director **Wacker Helderle**
(b) Address **3634 Gravois Ave.**

19. (a) **MAY 8 1944** (Date received local registrar)
J. F. Bredsch (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **May** day **6** year **1944** hour **11** minute **10** P. M.

21. I hereby certify that I attended the deceased from **July 13** 19**44** to **May 6** 19**44**
that I last saw **her** alive on **May 5** 19**44**
and that death occurred on the date and hour stated above.

Immediate cause of death **Chronic Myocarditis**
Pulmonary Embolism
Duration **?**

Due to **Arterio Sclerosis**

Due to _____
Other conditions (Include pregnancy within 3 months of death) **93**

Major findings: Of operations _____
Of autopsy _____
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? _____

(Specify type of place) _____
While at work _____ (e) Means of injury _____
23. Signature **L. O. Herkness** (M. D. or other)
Address **5600 S. Broadway** Date signed **5/8/44**

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

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.....

Licensed Embalmer No.....

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.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUSTHE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATHState File No. *May*Registration District No. *318*Primary Registration District No. *1003*Registrar's No. *4263*

1. PLACE OF DEATH:

(a) County.....
 (b) City or town..... *St. Louis*
 (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
 In this community.....
 years, months or days)

3. (a) PRINT
FULL NAME*Deana Hubner*3. (b) If veteran,
name war.....3. (c) Social Security
No.....4. Sex *F* 5. Color or race *W* 6. (a) Single, widowed, married,
divorced *W*6. (b) Name of husband or wife..... 6. (c) Age of husband or wife if
alive..... years7. Birth date of deceased..... *Dec 21 1914*
(Month) (Day) (Year)8. AGE: Years Months Days Unless than one day
92 4 10 min.9. Birthplace..... *Primary*
(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) *May 16 1944*19. (a) (Date received local report) (b) *J. F. Bradack*
(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) Citizen of foreign country?..... (Yes or No)
 If yes, name country.....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month *May* day *16*
year *1944* hour..... minute..... M.21. I hereby certify that I attended the deceased from....., 19.....;
that I last saw him..... alive on....., 19.....;
and that death occurred on the date and hour stated above.
Immediate cause of death.....

Duration

Due to.....

Due to.....

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

Major findings:

Of operations.....

Of autopsy.....

PHYSICIAN

Underline
the cause to
which death
should be
charged sta-
tistically.

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)

(e) Means of injury.....

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

Address..... Date signed.....

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

SUPPLEMENTARY

12928