S. No. 2
M—4-13-40
v. 5-17-39
I X23159

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 25533

FILED JUL 24 1944

Registration District No. ____ Primary Registration District No. 3058 Registrar's No. 100

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9
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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:
(a) County St. Charles
(b) City or town St. Charles
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: St. Joseph Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution Seven Days (Specify whether
In this community ____ years, months or days) 0

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County St. Charles
(c) City or town Boschertown 92
(If outside city or town limits, write "RURAL") 0
(d) Street No. Rural Route #3 0
(If rural, give location)
(e) If foreign born, how long in U. S. A.? Sixty Four! years.

3. (a) PRINT FULL NAME John A. HUBER

3. (b) If veteran, name war No

3. (c) Social Security No. None

4. Sex Male 0

5. Color or race White

6. (a) Single, widowed, married, divorced Widowed 2

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

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

7. Birth date of deceased April (Month) 6 (Day) 1862 (Year)

8. AGE: Years 82 Months 2 Days 14 If less than one day ____ hr. ____ min.

9. Birthplace Baden (City, town, or county) 4 Germany (State or foreign country)

10. Usual occupation Retired Farmer

11. Industry or business

MOTHER FATHER
12. Name Unknown
13. Birthplace Unknown (City, town, or county) 9 (State or foreign country)
14. Maiden name Mary Decker
15. Birthplace (City, town, or county) 4 Germany (State or foreign country)

16. (a) Informant Mrs Matt Bextermiller
(b) Address St Charles Mo. R 3

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-23-1944 (Month) (Day) (Year)
(c) Place: burial or cremation St Joseph Cemetary - Alton Ill

18. (a) Signature of funeral director John A. Hoehn
(b) Address Alton Ills

19. (a) 6-23-1944 (Date received local registrar) (b) Ernst E. Paul (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 20
year 1944 hour ____ minute ____ M.

21. I hereby certify that I attended the deceased from June 10-44, 19__, to June 20, 1944;
that I last saw him alive on June 30, 1944;
and that death occurred on the date and hour stated above.

Immediate cause of death Respiratory paralysis

Due to Spinal anaesthesia

Due to Prostatectomy 13 a

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations Abscess prostate with Hyperprostate
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?
(Specify type of place)
While at work? (e) Means of injury

23. Signature J. J. Tainter 0 (M. D. or other)
Address 505 Park Date signed 6/23-44

1340

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 9,

District File Number.....

Date Filed 7-22-44

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 A. Hoehn

Licensed Embalmer No. 1842

P. O. Address Alton Ills

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.