

V. S. No. 2
100M-5-43
Rev. 5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED JAN 11 1945

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **40172**
Registrar's No. **5286**

Registration District No. **149**

Primary Registration District No. **1002**

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

1. PLACE OF DEATH:
 (a) County Jackson
 (b) City or town Kansas City
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: Menorah Hospital
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 9 days **0**
 In this community 65 years (Specify whether years, months or days)

3. (a) PRINT FULL NAME MRS. ANNA HUEBNER
 3. (b) If veteran, name war XX
 3. (c) Social Security No. No

4. Sex Fe 5. Color or race Wh
 6. (a) Single, widowed, married, divorced Widowed
 6. (b) Name of husband or wife George Huebner
 6. (c) Age of husband or wife if alive XX years 28 1866
 7. Birth date of deceased: January 28 1866
 (Month) (Day) (Year)

8. AGE: Years 78 Months 10 Days 26
 If less than one day hr. min.

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

10. Usual occupation At Home

11. Industry or business

MOTHER FATHER

12. Name Peter Lillig

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

14. Maiden name No Record

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

16. (a) Informant Miss Clotilde Huebner

(b) Address 4410 Genesee

17. (a) Burial (b) Date thereof 12-28-44
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mt. St. Mary's

18. (a) Signature of funeral director J. M. Wagner
Kansas City, Mo.

(b) Address

19. (a) 12-27-44 (b) P. E. Brown
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
 (a) State Missouri (b) County Jackson **48**
 (c) City or town Kansas City **3**
 (If outside city or town limits, write "RURAL")
 (d) Street No. 4410 Genesee **7**
 (If rural, give location)
 (e) Citizen of foreign country? No (Yes or No)
 If yes, name country

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month Dec. 24th
 year 1944 hour 5: minute 45 P. M.

21. I hereby certify that I attended the deceased from Dec 15 1944 to Dec 24 1944
 that I last saw her alive on Dec 24 1944
 and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral apoplexy **2 days**
 Due to

Due to Suffered fracture of both wrists in fall at house **10 days**
 Other conditions (Include pregnancy within 3 months of death)

Major findings: 430
 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) (e) Nature of injury

23. Signature Walter S. Roberts (M. D. or other)

Address 420 Prof Bldg Date signed 12-27

11-2737
Duff

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 Alvin R. Hauschell
Licensed Embalmer No. 4159
P. O. Address: J. C. W.

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.