

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's Hospital
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 10 days
(Specify whether years, months or days)

3. (a) PRINT FULL NAME Theodore W. Hukriede
 3. (b) If veteran, name war ✓
 3. (c) Social Security No. ✓

4. Sex male 5. Color or race white
 6. (a) Single, widowed, married, divorced, widowed
 6. (b) Name of husband or wife _____
 6. (c) Age of husband or wife if alive _____ years
 7. Birth date of deceased November 9, 1878
(Month) (Day) (Year)

8. AGE: Years 66 Months 5 Days 5
 If less than one day _____ hr. _____ min.

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

10. Usual occupation Attorney at law

11. Industry or business _____

MOTHER FATHER
 12. Name Frederick Hukriede
 13. Birthplace Germany
(City, town, or county) (State or foreign country)
 14. Maiden name Caroline Drunert
 15. Birthplace Germany
(City, town, or county) (State or foreign country)

16. (a) Informant Herbert Hukriede
 (b) Address Warrenton, Mo.

17. (a) Burial (b) Date thereof 4-17-45
(Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation Warrenton, Mo.

18. (a) Signature of funeral director J. W. Nieburg & Co.
 (b) Address Warrenton, Mo.

19. (a) 4/14/45 (b) Emil A. Paul
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
 (a) State Missouri (b) County Warren 109
 (c) City or town Warrenton
(If outside city or town limits, write "RURAL")
 (d) Street No. _____
(If rural, give location)
 (e) Citizen of foreign country? no (Yes or No)
 If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 14
 year 1945 hour 7:05 minute A. M.

21. I hereby certify that I attended the deceased from Apr 7-45
 _____, 1945, to Apr 14, 1945;
 that I last saw him alive on Apr 13, 1945;
 and that death occurred on the date and hour stated above.

Immediate cause of death themia
 Duration _____

Due to Hyperplasia
 Due to _____

Other conditions Hyperplasia Prostate
(Include pregnancy within 3 months of death)

Major findings: Hyperplasia Prostate
 Of operations _____
 Of autopsy _____
ADDITIONAL SUPPLEMENTARY INFORMATION

22. If death was due to external causes, DISQUISHED
 (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 J. W. Nieburg (M. D. or other) _____
 Address 505 Clark Date signed Apr 14-45

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RECEIVED

District Health Officer No. 9,

District File Number.....

Date Filed 5-9-45

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 J. Meburg

Licensed Embalmer No.....

3897

P. O. Address.....

Waverly, Ind

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. mayRegistrar's No. 530Registration District No. 310Primary Registration District No. 3058

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:

(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

Theodore W. Hukriede

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex m5. Color or race w6. (a) Single, widowed, married, divorced w

6. (b) Name of husband or wife _____

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

7. Birth date of deceased Nov 9 1905

(Month)

(Day)

(Year)

8. AGE:

Years 66Months 5

Days _____

If less than one day _____ min.

9. Birthplace _____

(City, town, or county)

(State or foreign country) Mo

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER

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) Address _____

19. (a) _____

(Date received local registrar)

(b) _____

(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 April year 1965 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 Ch. nephritis

Due to _____

Other conditions _____
(Include pregnancy within 3 months of death)Major findings: ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED
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?

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

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