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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED SEP 17 1948

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

30753

State File No. 15

Registration District No. 305

Primary Registration District No. 6046

Registrar's No. 15

1. PLACE OF DEATH:

(a) County: St, Charles

(b) City or town: Rural Callaway
(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: None (Specify whether years, months or days)

In this community: 5years

2. USUAL RESIDENCE OF DECEASED:

(a) State: Mo (b) County: St, Charles 92

(c) City or town: Rural 0
(If outside city or town limits, write "RURAL")

(d) Street No.: Near Wentzville
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME: Vicia Hubbard

3. (b) If veteran, name war

3. (c) Social Security No. None

4. Sex: F

5. Color or race: W

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: Nov. (Month) 17 (Day) 1861 (Year)

8. AGE:	Years	Months	Days	If less than one day
	86	9	24	hr. min.

9. Birthplace: St, Charles Co. (City, town, or county) 0 (State or foreign country)

10. Usual occupation: Housewife

11. Industry or business

FATHER

12. Name: Richard Nicklos

13. Birthplace: (City, town, or county) Mo. (State or foreign country) 0

MOTHER

14. Maiden name: Susin Doyl

15. Birthplace: (City, town, or county) Mo. (State or foreign country) 0

16. (a) Informant

(b) Address: 5854 Elembark St, Louis, Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: 9-10-48 (Month) (Day) (Year)

(c) Place: burial or cremation: Wentzville,

18. (a) Signature of funeral director

(b) Address: Wentzville, Mo.

19. (a) 9/13/48 (Date received local registrar) (b) W.F. Puff (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month: September day: 8 year: 1948 hour: 5 minute: A M.

21. I hereby certify that I attended the deceased from DECEMBER 10, 1945, to Sept 7, 1948; that I last saw HER alive on Sept 7, 1948; and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Myocardial Degeneration	2 yrs
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 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: W.E. Borgesen (M. D. or other) D.O.

Address: Wentzville, Mo. Date signed: 9-9-48

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 9,
District File Number----------
Date Filed _____

SEP 30 1948

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 Howard O Kussler, Registered Apprentice No. 201 working under my personal supervision.

Signed Marin Muschany

Licensed Embalmer No. 2461

P. O. Address Westmoreland

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.

o. 2B
-3-45
I X43880

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BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. Sept

Registration District No. 305 Primary Registration District No. 6046 Registrar's No. 15

1. PLACE OF DEATH:
(a) County St Charles
(b) City or town Rural
(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 years, months or days)
In this community

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

3. (a) PRINT FULL NAME Vera Hubbard
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 wid
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive years
7. Birth date of deceased Nov 17 1862 (Month) (Day) (Year)
8. AGE: Years 86 Months Days If less than one day hr. min.
9. Birthplace (City, town, or county) Mo (State or foreign country)
10. Usual occupation
11. Industry or business Retired Housewife
MOTHER FATHER
12. Name
13. Birthplace (City, town, or county) (State or foreign country)
MOTHER
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)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month year 1948 hour minute M.
21. I hereby certify that I attended the deceased from , 19 to , 19 ; that I last saw h 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 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 (M. D. or other)
Address Date signed

SUPPLEMENTARY

S-30753