

FILED JUN 10 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

15937

State File No. 2238

BIRTH NO. _____		REG. DIST. NO. <u>149</u>		PRIMARY REG. DIST. NO. <u>1002</u>		Registrar's No. <u>2238</u>	
1. PLACE OF DEATH a. COUNTY <u>Jackson</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Jackson</u>			
b. CITY (If outside corporate limits, write RURAL and give OR TOWN <u>Kansas City</u>)		c. LENGTH OF STAY (in this place) <u>2 days</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Kansas City</u>		d. STREET ADDRESS (If rural, give location) <u>6001 E. 11th Street</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>K.C. General Hospital</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>May 20 1949</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>Robert</u>		b. (Middle) <u>E.</u>		c. (Last) <u>Hubrecht</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>May 20 1949</u>	
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Wh</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Wid</u>		8. DATE OF BIRTH <u>7/1/1868</u>	
9. AGE (in years last birthday) <u>80</u>		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 1 HR. Hours _____ Min. _____		11. BIRTHPLACE (State or foreign country) <u>Warsaw, Mo</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>--</u>		11. BIRTHPLACE (State or foreign country) <u>Warsaw, Mo</u>		12. CITIZEN OF WHAT COUNTRY? <u>US</u>	
13a. FATHER'S NAME <u>Herman Hubrecht</u>			13b. MOTHER'S MAIDEN NAME <u>Maria Carrington</u>			14. NAME OF HUSBAND OR WIFE <u>Sylvia Hubrecht</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>no</u>		17. INFORMANT'S SIGNATURE OR NAME <u>Miss Violet Hubrecht</u>		ADDRESS _____	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cirrhosis of the Liver</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death. <u>5810</u>				INTERVAL BETWEEN ONSET AND DEATH _____	
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify) _____		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) _____			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? _____			
22. I hereby certify that I attended the deceased from <u>5-4</u> , 19 <u>49</u> , to <u>5-20</u> , 19 <u>49</u> , that I last saw the deceased alive on <u>5-21</u> , 19 <u>49</u> , and that death occurred at <u>5:00 P</u> m., from the causes and on the date stated above.							
23a. SIGNATURE <u>Wm. W. Hart</u> (Degree or title) <u>M.D.C.</u>				23b. ADDRESS <u>Med. Dir. K.C. Gen. Hospital</u>		23c. DATE SIGNED <u>5-21-49</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>5/23/49</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Mt. Washington</u>		24d. LOCATION (City, town, or county) (State) <u>Kansas City, Mo.</u>	
DATE REC'D BY LOCAL REG. <u>5-23-49</u>		REGISTRAR'S SIGNATURE <u>Seraldine Holmes</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>John P. Shield</u>		ADDRESS <u>Kansas City, Mo.</u>	

WRITE PLAINLY—USING 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.....

.....
working under my personal supervision.

Student Embalmer No.....

Signed.....

John W. Shiel

Signed.....
Student Embalmer

Licensed Embalmer No. 3625

P. O. Address K. G. Rd.

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.