

FILED AUG 20 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **28987**
Registrar's No. **6367**

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Mo. b. COUNTY St. Louis	
b. CITY (If outside corporate limits, write RURAL and give township) St. Louis		c. CITY (If outside corporate limits, write RURAL and give township) Normandy #17	
d. FULL NAME OF HOSPITAL OR INSTITUTION 6119 Easton		d. STREET ADDRESS (If rural, give location) 3719 Oakmount	

3. NAME OF DECEASED (Type or Print) a. (First) Robert	b. (Middle) Keith	c. (Last) Hubbell	4. DATE OF DEATH (Month) (Day) (Year) July II 1954
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5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH April 7 1890	9. AGE (In years last birthday) 64	IF UNDER 1 YEAR Months	IF UNDER 11 HRS. Days	Hours	Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Jeweler	10b. KIND OF BUSINESS OR INDUSTRY Retail Prop	11. BIRTHPLACE (City and State or Foreign Country) Highland Ill.	12. CITIZEN OF WHAT COUNTRY? U S A
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13a. FATHER'S NAME Hubbell	13b. MOTHER'S MAIDEN NAME Medora Keith	14. NAME OF HUSBAND OR WIFE Eleanor Mc Hugh Hubbell
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No.	16. SOCIAL SECURITY NO. 495 36 838T	17. INFORMANT'S SIGNATURE OR NAME James Hubbell	ADDRESS 2611 Kinemore
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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, asthma, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH few mins
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary Occlusion		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Coronary Insufficiency		6 mos
	DUE TO (c) Generalized Arteriosclerosis		
II. OTHER SIGNIFICANT CONDITIONS* Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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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)
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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? 4801
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22. I hereby certify that I attended the deceased from **7-6-1954** to **7-11-1954**, that I last saw the deceased alive on **7-6-1954**, and that death occurred at **10 55A**, from the causes and on the date stated above.

23a. SIGNATURE Albert Kaplan MD	(Degree or title) MD	23b. ADDRESS 607 N. Grand	23c. DATE SIGNED 7-12-54
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE July 14 54	24c. NAME OF CEMETERY OR CREMATORY Calvary	24d. LOCATION (City, town, or county) (State) St. Louis Mo.
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DATE REC'D BY LOCAL REG. JUL 13 1954	REGISTRAR'S SIGNATURE Carl Smith MD	25. FUNERAL DIRECTOR'S SIGNATURE Cullen Kelly	ADDRESS 7267 Nat'l Bridge
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(Licensed Embalmer's Statement on Reverse Side)

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 _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed James A. Lammer

Licensed Embalmer No. 4142

P. O. Address St Louis

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.