

FILED SEP 2 1955

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

26986

State File No.

BIRTH NO.		REG. DIST. NO. <u>209</u>		PRIMARY REG. DIST. NO. <u>3043</u>		Registrar's No. <u>257</u>			
1. PLACE OF DEATH a. COUNTY <u>Marion</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Marion</u>					
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Hannibal</u>		c. LENGTH OF STAY (If in this place) <u>1 day</u>		c. CITY OR TOWN <u>Hannibal</u>		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>			
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>St. Elizabeth Hosp</u>				STREET ADDRESS (If rural, give location) <u>907 15th St. 064</u>					
3. NAME OF DECEASED (Type or Print) <u>WILLIAM DANIEL WESLEY HUBERT</u>			a. (First)		b. (Middle)		c. (Last)		
4. DATE OF DEATH <u>AUG 22 1955</u>		(Month)		(Day)		(Year)			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>3</u>		8. DATE OF BIRTH <u>June 17-1888</u>		9. AGE (In years last birthday) <u>67</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and State or Foreign Country) <u>Frankford Mo. 0</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A</u>			
13a. FATHER'S NAME <u>William Hubert</u>			13b. MOTHER'S MAIDEN NAME <u>Mary Jane Hudson</u>			14. NAME OF HUSBAND OR WIFE <u>Nora Hubert</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>✓</u>		17. INFORMANT'S SIGNATURE OR NAME <u>Mrs. Edna Utterbach</u>				ADDRESS <u>729 50th St. Frankford Mo.</u>	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)				MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* <u>Chronic myocarditis</u>				DUPLICATE OF (a) <u>Chronic myocarditis</u>				<u>2 months.</u>	
*This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.				ANTECEDENT CAUSES					
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.				DUE TO (b) <u>Arteriosclerosis, generalized.</u>				<u>2 months.</u>	
				DUE TO (c) <u>4221</u>					
II. OTHER SIGNIFICANT CONDITIONS				Conditions contributing to the death but not related to the disease or condition causing death. <u>Ruptured esophageal varix.</u>				<u>1 week</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION						20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify) <u>--</u>		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>--</u>		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)					
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		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>8/15</u> , 19 <u>55</u> , to <u>8/22</u> , 1955, that I last saw the deceased alive on <u>8/22</u> , 19 <u>55</u> , and that death occurred at <u>3:10p m.</u> , from the causes and on the date stated above.									
23a. SIGNATURE (Deceased or title) <u>Reuben Flannery MD</u>				23b. ADDRESS <u>Hannibal, Mo.</u>			23c. DATE SIGNED <u>8/24/55.</u>		
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>Aug. 25-55</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Fairview Cemetery</u>		24d. LOCATION (City, town, or county) (State) <u>Frankford Missouri</u>			
DATE REC'D BY LOCAL REG. <u>8-25-55</u>		REGISTRAR'S SIGNATURE <u>Dr. C. M. Lucke</u>		199-01 <u>By W. C. Fisher</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Fisher & Son</u>			
						ADDRESS <u>Frankford Mo.</u>			

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED AUG 31 1955

MARION CO. HEALTH DEPT.

DATE FILED AUG 31 1955

SEP 1 1955

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was
by me, or by, Student Embalmer No....
working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed *Jose Fields Meza*

Licensed Embalmer No.....

P. O. Address *Frank*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING
to comply with the above constitutes grounds for revocation of license).
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.