

**FRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**

**=60-021084**

**FILED VS MAY 18 1960**

**318**

**1003**

**4893**

STATE FILE NUMBER

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar's No. \_\_\_\_\_

|   |   |   |  |  |   |  |
|---|---|---|--|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY  |   |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Illinois</b> b. COUNTY <b>White</b> |  |   |  |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR<br>TOWN <b>ST. LOUIS, MISSOURI</b>  |   | Length of stay in 1b  | c. CITY OR TOWN <b>Carmi</b>   |  | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input checked="" type="checkbox"/> |  |
| c. FULL NAME OF HOSPITAL OR INSTITUTION <b>BARNES HOSPITAL</b>  |   |   | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>   | d. STREET ADDRESS (If outside, give location)<br><b>Montgomery Circle</b>  |   |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>WILLIAM</b> Middle <b>C.</b> Last <b>HUBER</b>  |   |   | 4. DATE OF DEATH<br>Month <b>MAY</b> Day <b>5</b> Year <b>1960</b>   |  |   |  |
| 5. SEX<br><b>Male</b>   | 6. COLOR OR RACE<br><b>White</b>  | 7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/><br>Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>2/7/1906</b>  | 9. AGE (last birthday)<br><b>54</b>  | IF UNDER 1 YEAR<br>Months _____ Days _____ Hours _____ Min. _____                               |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>General Manager</b>   |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>City Power Co.</b>  |  | 11. BIRTHPLACE (City and state or country)<br><b>Carmi, Ill.</b>   | 12. CITIZEN OF WHAT COUNTRY<br><b>U.S.</b>  |  |
| 13a. FATHER'S NAME<br><b>Walter G. Huber</b>  |   | 13b. MOTHER'S MAIDEN NAME<br><b>Maria Werner</b>  |  | 14. NAME OF HUSBAND OR WIFE<br><b>Jane</b>   |   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>No</b>  |   | 16. SOCIAL SECURITY NO.<br><b>Unknown</b>   |  | 17. INFORMANT<br><b>Jane Huber, Carmi, Ill.</b>  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>DISSEMINATED FUNGAL DISEASE OF RIGHT LUNG (HISTOPLASMOVIS SUSPECTED)</b>   |   |   |  |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>UNKNOWN</b>  |  |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.<br>DUE TO (b) _____<br>DUE TO (c) _____ <b>134.2</b>   |   |   |  |  |   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)   |   |   |  | PART III. If deceased was female was there a pregnancy in last 90 days.<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown |   |  |
| 19. WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   | 20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/> | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)  |  |  |   |  |
| 20c. TIME OF INJURY<br>Hour _____<br>a.m. _____<br>p.m. _____   | Month, Day, Year  |   |  |  |   |  |
| 20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  | 20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                  | 20f. CITY, TOWN, OR LOCATION  |  | COUNTY   | STATE   |  |
| 21. I attended the deceased from <b>JAN 6, 1943</b> to <b>J MAY 5, 1960</b> and last saw her/him alive on <b>MAY 5, 1960</b><br>Death occurred at <b>7:15 P.M.</b> on the date stated above, and to the best of my knowledge, from the causes stated. |   |   |  |  |   |  |
| 22a. SIGNATURE (Degree or title)<br><b>C. O. Williams, M.D.</b>   |   |   | 22b. ADDRESS<br><b>BARNES HOSPITAL</b>   |  | 22c. DATE SIGNED<br><b>5/5/60</b>   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Removal</b>   | 23b. DATE<br><b>5-8-60</b>  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Maple Ridge Cemetery</b>   |  | 23d. LOCATION (City, town, or county) (State)<br><b>Carmi, Ill.</b>  |   |  |
| 24. FUNERAL DIRECTOR<br><b>Albert H. Hoppe, Inc., 4700 Washington Blvd.</b>   |   | ADDRESS   |  | 25. DATE RECD. BY LOCAL REG.<br><b>MAY 9 1960</b>  | 26. REGISTRAR'S SIGNATURE<br><b>Paul Smith, M.D.</b>  |  |

Created - not every histoplasmosis case is 3/12/60  
 DOCUMENT  
 MEDICAL CERTIFICATION  
 BY AFFIDAVIT OF

**STATEMENT BY LICENSED EMBALMER**

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

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed J. W. B. Bentley  
Licensed Embalmer No. 365  
P. O. Address J. W. Bentley

Note: The above ~~statement~~ **MUST BE SIGNED BY THE LICENSED EMBALMER** in his OWN HANDWRITING. (Failure to do 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.