No. 2
8-43
17-39
X37823

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 10068

FILED MAR 27 1946

Registration District No. ____ Primary Registration District No. 4314 Registrar's No. ____

1. PLACE OF DEATH:

(a) County Macon
(b) City or town La Plata
(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
In this community 34
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Macon
(c) City or town La Plata
(If outside city or town limits, write "RURAL")
(d) Street No. —
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country ____

3. (a) PRINT FULL NAME Charley Henry Huebner
3. (b) If veteran, name war —
3. (c) Social Security No. —

4. Sex M
5. Color or race W
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Clara Huebner
6. (c) Age of husband or wife if alive 69 years
7. Birth date of deceased Aug (Month) 25 (Day) 1877 (Year)

8. AGE: Years	Months	Days	If less than one day
68	5	10	____ hr. ____ min.

9. Birthplace Macon (City, town, or county) — (State or foreign country)
10. Usual occupation Farmer
11. Industry or business ____

FATHER
12. Name Henry Huebner
13. Birthplace Germany (City, town, or county) — (State or foreign country)

MOTHER
14. Maiden name Lord Lautberg
15. Birthplace Germany (City, town, or county) — (State or foreign country)

16. (a) Informant Elgra Huebner
(b) Address La Plata Mo
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 7-1946 (Month) (Day) (Year)
(c) Place: burial or cremation Holland Park Cemetery
18. (a) Signature of funeral director [illegible] Schuster
(b) Address La Plata Mo
19. (a) 2-7-1946 (Date received local registrar) (b) Mrs O. B. Griffin (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb. day 5
year 1946 hour ____ minute ____ M.
21. I hereby certify that I attended the deceased from Jan. 31, 1946 to Feb. 5, 1946 that I last saw h~~im~~ alive on Feb. 5, 1946. and that death occurred on the date and hour stated above.

Immediate cause of death	C	Duration
Chronic Nephritis.		Dt. short.
Uremia.		
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 Est. Guernsey (M. D. or [illegible])
Address La Plata Mo Date signed 2-6-46

186

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 10
District File Number 3-46-579
Date Filed MAR 19 1946

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 ✓

....., Registered Apprentice No. ✓

working under my personal supervision.

Signed D. S. Hendricks

Licensed Embalmer No. 1109

P. O. Address La Plata Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wit the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

No. 2B
—3-45
P I X43880

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. APRIL

Registration District No. 207 Primary Registration District No. 4315 Registrar's No.

1. PLACE OF DEATH:

(a) County Macon

(b) City or town Labelle

(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

In this community years, months or days)

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 Charley H. Hulbert

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex M

5. Color or race W

6. (a) Single, widowed, married, divorced M

6. (b) Name of husband or wife

6. (c) Age of husband or wife if alive years

7. Birth date of deceased aug 25 (Month) (Day) (Year)

8. AGE: Years 68 Months 5 Days If less than one day hr. min.

9. Birthplace (City, town, or county) Iowa (State or foreign country)

10. Usual occupation

11. Industry or business

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) 12-7-46 (Date received local registrar) (b) Mrs O B Hyffin (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month dec Day 6 year 1946 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.

	Duration
Immediate cause of death	
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

10068