MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Do not use this space.

31902

1. PLACE OF DEATH

County ..... Registration District No. 791

Township ..... Primary Registration District No. 1003

City ..... (No. 4054 Lincoln Ave. St. ..... Ward)

File No. .....

Registered No. 8912

2. FULL NAME Emily Aubuchon

(a) Residence. No. 4054 Lincoln Ave St., 11 Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word): Widow

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF: John Aubuchon

6. DATE OF BIRTH (MONTH, DAY AND YEAR): About 1847

7. AGE: About 82 YEARS MONTHS DAYS Unknown If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Retired

(b) General nature of industry, business, or establishment in which employed (or employer): at home

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) ..... (STATE OR COUNTRY) Florisant Mo

PARENTS

10. NAME OF FATHER: John Larney

11. BIRTHPLACE OF FATHER (CITY OR TOWN) ..... (STATE OR COUNTRY) Florisant Mo

12. MAIDEN NAME OF MOTHER: Victoria Teason

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) ..... (STATE OR COUNTRY) Florisant Mo

14. INFORMANT: Ben Aubuchon
(Address) 4054 Lincoln Ave

15. FILED SEP -3 1929 Max C Harkey REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): Sept 2 1929

17. I HEREBY CERTIFY, That I attended deceased from Sept 1, 1929, to Sept 2, 1929 that I last saw her alive on Sept 1, 1929, and that death occurred, on the date stated above, at 10 A m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Senility

92C

182

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY): Myocarditis Chronic

..... (duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH? X

DID AN OPERATION PRECEDE DEATH? no DATE OF X

WAS THERE AN AUTOPSY? X

WHAT TEST CONFIRMED DIAGNOSIS? X

(Signed) H. M. Foster, M.D.

, 19 (Address) 4065 St Louis Ave

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL: St Ferdinand Cemetery

DATE OF BURIAL: 9-4 1929

20. UNDERTAKER: Geo. E. Mahler

ADDRESS: 4725 St Louis

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

WHITE PERMANENT, WITH UNFADING INK—THIS IS A PERMANENT RECORD