

No. 2
-11-10-39
5-17-39
-1 X21492

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

13462

State File No. _____

Registrar's No. **3664**

MAY 15 1940
Registration District No. **791**

Primary Registration District No. **1003**

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

1. PLACE OF DEATH:

(a) County _____
(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 906 Aubert Ave
(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 Missouri (b) County _____
(c) City or town St. Louis (If outside city or town limit, write "RURAL")
(d) Street No. 906 Aubert Ave. (If rural, give location)
(e) If foreign born, how long in U. S. A. ? _____ years.

3. (a) PRINT FULL NAME Irene Roach
3. (b) If veteran, name war No 3. (c) Social Security No. 492-10-5638

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Widowed
6. (b) Name of husband or wife John J. Roach 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased October 2 1889
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
50 6 20 hr. _____ min.

9. Birthplace St. Louis Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation Cook (Busy Bae)

11. Industry or business Candy Manufactures

MOTHER FATHER { 12. Name August Aubuchon
13. Birthplace Florissant Missouri
(City, town, or county) (State or foreign country)
14. Maiden name Kate Keelan
15. Birthplace St. Louis
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs Adele Smith
(b) Address 1386 Hodiamont Ave

17. (a) Burial (b) Date thereof April 24 1940
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Galvary Cemetery

18. (a) Signature of funeral director [Signature]
(b) Address 1225 Union Blvd.

19. (a) APR 23 1940
(Date received local registrar) (Signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 22
year 1940 hour 12 30 minute A M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
that I last saw him _____ alive on _____, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Haemorrhage
(Apoplexy)
Due to _____
Due to _____
Other conditions (Include pregnancy within 3 months of death) _____

Major findings: _____
Of operations _____
Of autopsy _____

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 [Signature] (M. D. or other)
Address Deputy Registrar Date signed _____

Duration _____
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

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 *Albert G. Lopp*.....

Licensed Embalmer No. *2971*.....

P. O. Address.....

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, above space should be left blank.