

Registration District No. **318** Primary Registration District No. **1003**

1. PLACE OF DEATH:
(a) County **St. Louis**
(b) City or town **St. Louis**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
St. Anthony's Hospital
(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)

3. (a) PRINT FULL NAME **Michael W. Aurin**
3. (b) If veteran, name war **None** 3. (c) Social Security No. **None**

4. Sex **Male** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **Single**
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased **April 20th 1943**
(Month) (Day) (Year)

8. AGE: Years **0** Months **2** Days **20** If less than one day _____ hr. _____ min.

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

10. Usual occupation **Infant**

11. Industry or business _____

MOTHER FATHER { 12. Name **John Aurin**
13. Birthplace **St. Louis Mo.**
(City, town, or county) (State or foreign country)
14. Maiden name **Dorothy Mae Voss**
15. Birthplace **St. Louis Mo.**
(City, town, or county) (State or foreign country)

16. (a) Informant **Dorothy Aurin**
(b) Address **3010 Salena St.**

17. (a) **Burial** (b) Date thereof **7-12-43**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Memorial Park Cemetery**

18. (a) Signature of funeral director **Kriegshauser Mortuary**
(b) Address **4228 So. Kingshighway Blvd.**

19. (a) **JUL 11 1943** (b) **J. J. Rudick**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED: **000 17 24**
(a) State **Mo.** (b) County _____
(c) City or town **St. Louis**
(If outside city or town limits, write "RURAL")
(d) Street No. **3010 Salena St.**
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **July** day **10th**
year **1943** hour **6:15** minute **A.M.**

21. I hereby certify that I attended the deceased from **June 28**
1943, to **July 10th**, **1943**.
that I last saw him alive on **July 9**, **1943**.
and that death occurred on the date and hour stated above.

Immediate cause of death **congenital atresia of the jejunum, 2 ft. below the stomach, in intestinal obstruction.**

Due to **also Pyloric obstruction of stomach due to hypertrophy**

Other conditions (Include pregnancy within 3 months of death) **15/1**

Major findings: Of operations: **Pyloric hypertrophy (6-30-43)**
Of autopsy: **congenital atresia of jejunum**

Duration **Since Birth**

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) **no**
(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?

23. Signature _____ (Specify type of place) _____ (M. D. or other) _____
Address **3805 S. Wilmington Ave.** Date signed **7-12-43**

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

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 *Edwin A. McNamee*

Licensed Embalmer No. *3024*

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, fact should be so stated above.