

FILED AUG 21 1944
377

Registration District No. _____

Primary Registration District No. 6076

1. PLACE OF DEATH:

(a) County St. Louis

(b) City or town Florissant
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
450 St. Joseph St.
(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 Mo. (b) County St. Louis

(c) City or town Florissant
(If outside city or town limits, write "RURAL")

(d) Street No. 450 St. Joseph St.
(If rural, give location)

(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME William Charlis Aubuchon

3. (b) If veteran, name war No

3. (c) Social Security No. None

4. Sex Male

5. Color or race White

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

6. (b) Name of husband or wife Cora Aubuchon alive _____ years

6. (c) Age of husband or wife if _____

7. Birth date of deceased Dec. 28, 1856
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day

87 7 13 hr. min.

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

10. Usual occupation Retired

11. Industry or business _____

MOTHER FATHER { 12. Name Francie Aubuchon

13. Birthplace Florissant, Mo.
(City, town, or county) (State or foreign country)

14. Maiden name Mary DeHater

15. Birthplace Florissant, Mo.
(City, town, or county) (State or foreign country)

16. (a) Informant Edmond Aubuchon

(b) Address Florissant, Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 14/44
(Month) (Day) (Year)

(c) Place: burial or cremation St. Ferdinand Cem.

18. (a) Signature of funeral director Jos. W. Clark

(b) Address 1125 Hodiament Ave.

19. (a) AUG 10 1944 (Date received local registrar)

(b) E. J. McHarran, M.D. (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug. day 10
year 1944 hour 6.30 minute A.M. M.

21. I hereby certify that I attended the deceased from July 27, 1944 to Aug. 9, 1944
that I last saw him alive on _____, 19____
and that death occurred on the date and hour stated above.

Immediate cause of death Chronic Myocarditis
Arteriosclerosis
Senility

Due to _____

Due to _____

Other conditions (Include pregnancy within 3 months of death) Gravid

Major findings: _____

Of operations _____

Of autopsy _____

Duration _____

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? _____

While at work? _____ (Specify type of place)

(c) Means of injury MI

23. Signature E. J. McHarran, M.D. (M. D. or other) MD

Address 7301 Natural Bridge Rd. Date signed 8-10-44

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

Dr. Wm. E. Moor
7301 Natural Bridge Road.

Dr. Wm. E. Moor
7301 Natural Bridge Road.

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 Joe W. Clark

Licensed Embalmer No. 1661

P. O. Address 1125 Hodiamont Ave.

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.