

318
JUN 30 1945
Registration District No.

Primary Registration District No.

Registrar's No.

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: Barnes Hospital,
(If not in hospital or institution, write street number & location)
(d) Length of stay: In hospital or institution 2 days
(Specify whether
In this community _____
years, months or days)

3. (a) PRINT FULL NAME William Aubuchon

3. (b) If veteran, name war Nil 3. (c) Social Security No. None

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Widower

6. (b) Name of husband or wife Margaret Jane Aubuchon 6. (c) Age of husband or wife if _____ years

7. Birth date of deceased November 6 1882
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
62 7 8 hr. min.

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

10. Usual occupation Mine Operator

11. Industry or business _____

12. Name Joseph Aubuchon

13. Birthplace Washington County Missouri
(City, town, or county) (State or foreign country)

14. Maiden name Sarah Parkin

15. Birthplace Washington County Missouri
(City, town, or county) (State or foreign country)

16. (a) Informant Ivan Aubuchon

(b) Address Festus, Mo.

17. (a) Burial (b) Date thereof 6-17-45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Festus, Missouri

18. (a) Signature of funeral director Albert H. Hoppe

(b) Address 4700 Washington Blvd.

19. (a) JUN 15 1945 (b) [Signature]
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jefferson
(c) City or town Festus
(If outside city or town limits, write "RURAL" and location)
(d) Street No. _____
(If rural, give location)
(e) Citizen of foreign country? / (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 14
year 1945 hour 7 minute 25 P.M.

21. I hereby certify that I attended the deceased from June 12 1945 to June 14 1945
that I last saw him alive on June 14 1945
and that death occurred on the date and hour stated above.

Immediate cause of death Hypertensive cardio vascular disease
C & V. diverting aneurysm
Due to _____

Due to _____

Other conditions (Include pregnancy within 3 months of death) 30

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 FR Bradley (M. D. or other) _____

Address Barnes Hospital, Date signed 6/15/45

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

MOTHER FATHER

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 Robert W. Kappel

Licensed Embalmer No.....

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.