

FILED JAN 31 1947

Registration District No. 219

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 3622

Registrar's No. 4

Primary Registration District No. 6078

1. PLACE OF DEATH:

(a) County STE. GENEVIEVE
 (b) City or town BAILEY'S - Rural
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: 1
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution NO (Specify whether
 In this community LIFE years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County STE. GENEVIEVE
 (c) City or town BAILEY'S
 (If outside city or town limits, write "RURAL")
 (d) Street No. Jackson Camp
 (If rural, give location)
 (e) Citizen of foreign country? NO (Yes or No)
 If yes, name country _____

3. (a) PRINT FULL NAME SUSAN AUBUCHON

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex FEMALE 5. Color or race WHITE
 6. (a) Single, widowed, married, divorced WIDOWED
 6. (b) Name of husband or wife LYNN AUBUCHON
 6. (c) Age of husband or wife if alive _____ years
 7. Birth date of deceased MAR 11 1876
 (Month) (Day) (Year)

8. AGE: Years 70 Months 10 Days 7
 If less than one day _____ hr. _____ min.

9. Birthplace STE. GENEVIEVE, CO MO
 (City, town, or county) (State or foreign country)

10. Usual occupation AT HOME

11. Industry or business _____

12. Name WALTER MC CARTY
 13. Birthplace UNKNOWN UNKNOWN
 (City, town, or county) (State or foreign country)
 14. Maiden name SARAH VINTARA
 15. Birthplace UNKNOWN UNKNOWN
 (City, town, or county) (State or foreign country)

16. (a) Informant Wesley H. Aubuchon
 (b) Address 118 N Mill Street Mo
 17. (a) BURIAL (b) Date thereof 1-21-47
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation EMERALD CEMETERY
 18. (a) Signature of funeral director W. C. Saylor
 (b) Address St. Genevieve Mo
 19. (a) Jan. 25 - 47 (b) Pyra M. Karl
 (Date received local registrar) (Registar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month JAN day 18
 year 1947 hour 8 minute 30 P. M.
 21. I hereby certify that I attended the deceased from Nov 15 - 1944
Jan 18 to Jan 18 1947
 that I last saw her alive on Jan 15 1947
 and that death occurred on the date and hour stated above.

Immediate cause of death Chronic Myocarditis
 Due to Atonia - Pclorica

Duration
15 yrs
7 yrs

Due to _____
 Other conditions _____
 (Include pregnancy within 3 months of death)

Major findings:
 Of operations g m d
 Of autopsy _____
 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 _____

23. Signature Robert H. Ranning (M. D. or other) M.D.
 Address St Genevieve Mo Date signed 1/19/47

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

MOTHER FATHER

RECEIVED

District Health Officer No. 4

District File Number 147-164

Date Filed 1-30-47

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 Geo. C. Basch

Licensed Embalmer No. 1985

P. O. Address St. Germaine Mo

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.