

FILED SEP 30 1947

Registration District No. **53**

Primary Registration District No. **3010**

Registrar's No. **286**

1. PLACE OF DEATH:
 (a) County **Cape Girardeau**
 (b) City or town **Cape Girardeau Mo.**
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
St. Francis Hospital
 (If not in hospital or institution, write street, apt. or location)
 (d) Length of stay: In hospital or institution **17 Hours Hospital**
 (Specify whether
 In this community **17 Hours**
 years, months or days)

2. USUAL RESIDENCE OF DECEASED:
 (a) State **Missouri** (b) County **Perry 79**
 (c) City or town **Perryville Mo.**
 (If outside city or town limits, write "RURAL")
 (d) Street No. _____ (If rural, give location)
 (e) Citizen of foreign country? **no** (Yes or No)
 If yes, name country _____

3. (a) PRINT FULL NAME **Louis William Aulback**

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

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

6. (b) Name of husband or wife _____ **6. (c) Age of husband or wife if**
 alive _____ years

7. Birth date of deceased **September 18 1947**
 (Month) (Day) (Year)

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

9. Birthplace **Perryville** **Mo.** **0**
 (City, town, or county) (State or foreign country)

10. Usual occupation **Inf**

11. Industry or business _____

12. Name **Curtis L. Aulback** **0**

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

14. Maiden name **Ruth Schindler**

15. Birthplace **Perryville** **Mo.** **0**
 (City, town, or county) (State or foreign country)

16. (a) Informant **William Schindler**

(b) Address **Perryville Mo.**

17. (a) Burial _____ **(b) Date thereof** **9-19-1947**
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Perryville Mo.**

18. (a) Signature of funeral director **Young Sons**

(b) Address **Perryville Mo.**

19. (a) 9-23-47 **(b) C. G. Summers**
 (Date received local registrar) (Registrar's signature)

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MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **September** 19 **19**
 year **1947** hour **9** minute **A** M.

21. I hereby certify that I attended the deceased from **Sept 18**, 19**47**, to **Sept 19**, 19**47**
 that I last saw him alive on **Sept 18**, 19**47**
 and that death occurred on the date and hour stated above.

Immediate cause of death _____ **Duration** _____

Due to **Prematurity**

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? _____

While at work? _____ (Specify type of place)

(e) Means of injury **0**

23. Signature **J. Cochran** (M. D. certifier)

Address **Cape Girardeau Mo.** **Date signed** **9/20/47**

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

Health Officer No. 4
File Number 947-1280
Date Filed 9-29-47

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.....

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.