S. No. 2
0M—5-43
ev. 5-17-39
o I X36671

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED SEP 18 1947
Registration District No. 310

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 3058

State File No. 32193

Registrar's No. 163

1. PLACE OF DEATH:
(a) County St. Charles
(b) City or town St. Charles
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: St. Joseph's Hospital 0
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 3 days (Specify whether
In this community Life years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County St. Louis 96
(c) City or town Florissant 0
(If outside city or town limits, write "RURAL")
(d) Street No. Route # 3 0
(If rural, give location)
(e) Citizen of foreign country? (Yes or No) /
If yes, name country

3. (a) PRINT FULL NAME Rosa L. Aubuchon
3. (b) If veteran, name war ---
3. (c) Social Security No. ---
4. Sex F / 5. Color or race W
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Larken P. Aubuchon
6. (c) Age of husband or wife if alive 64 years
7. Birth date of deceased November (Month) 6 (Day) 1887 (Year)

8. AGE: Years 59 | Months 9 | Days 26 | If less than one day hr. min.

9. Birthplace Florissant (City, town, or county) Missouri (State or foreign country) 0
10. Usual occupation Housewife
11. Industry or business ---
FATHER 12. Name August Teson
13. Birthplace Missouri 0 (City, town, or county) (State or foreign country)
MOTHER 14. Maiden name Susan Lajeuness
15. Birthplace Missouri 0 (City, town, or county) (State or foreign country)
16. (a) Informant Larken P. Teson
(b) Address Florissant, Missouri
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/4/47 (Month) (Day) (Year)
(c) Place: burial or cremation St. Ferdinand Cemetery
18. (a) Signature of funeral director White Funeral Home
(b) Address Ferguson, Missouri
19. (a) 9/4/47 (Date received by local registrar) (b) Fannie Hamacher (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept. day 1
year 1947 hour 9 minute P. M.
21. I hereby certify that I attended the deceased from 11-20-43 19 to 9-1-47 19 47;
that I last saw her alive on 9-1-47 19;
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Cerebral hemorrhage	5 days
Due to hypertension	10 yrs
Due to arteriosclerosis	15 yrs
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations None	
Of autopsy None	

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 None
(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 0

23. Signature Ira L. Faucett M.D. (M.D. or other)
Address 207 N. 5th St. Date signed 9/3/47

(Licensed Embalmer's Statement on Reverse Side)

Date Filed SEP 17 1947

District File Number

Di[illegible] Officer No. 9,

RE[illegible]

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 L. M. White

Licensed Embalmer No. 3973

P. O. Address Ferguson, 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.