S. No. 2
1—1/47
. 5-17-39

FEDERAL SECURITY AGENCY
National Office of Vital Statistics

FILED NOV 6 1947

Registration District No.

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 6076

State File No. 36584

Registrar's No. 2300

1. PLACE OF DEATH:

(a) County: St. Louis

(b) City or town: St. Louis
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Shamrock Rest Home
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution (Specify whether years, months or days)

In this community

2. USUAL RESIDENCE OF DECEASED:

(a) State: Mo. (b) County:

(c) City or town: St. Louis
(If outside city or town limits, write "RURAL")

(d) Street No.: 5129A Wabada Ave.
(If rural, give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME: Aurelia 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: Robert Aubuchon

6. (c) Age of husband or wife if alive: years

7. Birth date of deceased: Apr. (Month) 29 (Day) 1879 (Year)

8. AGE: Years	Months	Days	If less than one day
68	6	1	hr. min.

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

10. Usual occupation: Home

11. Industry or business:

FATHER
12. Name: August Teson
13. Birthplace: (City, town, or county) Mo. (State or foreign country)

MOTHER
14. Maiden name: Susan Lahuneau
15. Birthplace: (City, town, or county) Mo. (State or foreign country)

16. (a) Informant: Lillian Aubuchon
(b) Address: 5239 Enright Ave.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: 11-1-47 (Month) (Day) (Year)
(c) Place: burial or cremation: St Ferdinands Cem.

18. (a) Signature of funeral director: Drehmann-Harral
(b) Address: 1905 Union Blvd

19. (a) 11-3-47 (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct. day 30 year 1947 hour 8 minute 40 A.M.

21. I hereby certify that I attended the deceased from 9-24-47 to Oct 30, 1947 and that I last saw her alive on Oct 30, 1947 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Coronary occlusion	Immediate
Due to: Hypertension 9 yr	
Due to: Arteriosclerotic Heart Disease	
Other conditions (Include pregnancy within 3 months of death): Hemiplegia	9 mos

Major findings:
Of operations: none
Of autopsy: none

PHYSICIAN: Underline the cause of which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify): no
(b) Date of occurrence: none
(c) Where did injury occur? (City or town) (County) (State): none
(d) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place): none
While at work? no (e) Means of injury: none

23. Signature: M. G. Steele (M. D. or other) M.D.
Address: 7124 Natural Bridge Date signed: Oct 31 47

Jefferson City Printing Co.

(Licensed Embalmer's Statement on Reverse Side)

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

MAR 8 1948
DEC 11 1947

7124 Natural Bridge
9 to 11

NOV 7 1947

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: Warren A. Carver

Licensed Embalmer No. 3534

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.