

No. 2  
12-45  
1-17-39  
2X47070

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

FILED JUL 31 1948

Registration District No. 302

Primary Registration District No. 3069

1. PLACE OF DEATH:

(a) County St. Louis County  
(b) City or town Richmond Mo  
(c) Name of hospital or institution St. Marys Hosp  
(d) Length of stay: In hospital or institution 17 months  
In this community 17 months

3. (a) PRINT FULL NAME Roy A. Aulderheide

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. none

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

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased August 1 1947

8. AGE: Years \_\_\_\_\_ Months 11 Days 16 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace St. Louis Mo

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

12. Name Milton Aulderheide

13. Birthplace St. Louis Mo

14. Maiden name Eloretta A. High

15. Birthplace Farmington Mo

16. (a) Informant Milton Aulderheide

(b) Address 6725 Scofield

17. (a) Burial (b) Date thereof July 20 1948

(c) Place: burial or cremation Hiram Cem

18. (a) Signature of funeral director protest Ind co

(b) Address 3210 W Grand

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Louis  
(c) City or town St. Louis  
(d) Street No. 6725 Scofield  
(e) Citizen of foreign country? \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 17th 7th  
year \_\_\_\_\_ hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_; that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_; and that death occurred on the date and hour stated above.

Immediate cause of death  
Bronchial Obstruction  
Bronchial Obstruction  
Due to foreign body  
Due to Tracheotomy  
Other conditions: Tracheitis  
Mediastinitis  
Major findings: Mediastinitis  
Of operations: Safety pin straddling into esophagus & larynx  
Of autopsy: safety pin straddling into esophagus and larynx

Duration  
15 days  
13 days  
13 days  
15 days  
10 days  
10 days  
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 \_\_\_\_\_  
Where did injury occur? \_\_\_\_\_  
(c) (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 \_\_\_\_\_

23. Signatures Jackson (M. D. or other) MD  
Address 631 N Grand Date signed 7/19/48

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.....

*Albert Mayfield*

Licensed Embalmer No.....

*13077*

P. O. Address.....

*St. Louis, 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.**

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. Aug  
Registrar's No. 171-0

Registration District No. 317 Primary Registration District No. 3069

1. PLACE OF DEATH:  
(a) County St Louis co  
(b) City or town Richmond Heights  
(If outside city or town limits, write "RURAL" and name of township)  
Name of hospital or institution:  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether \_\_\_\_\_)  
Community \_\_\_\_\_ (Specify whether \_\_\_\_\_)  
Years, months or days \_\_\_\_\_

2. USUAL RESIDENCE OF DECEASED:  
State \_\_\_\_\_ (b) County \_\_\_\_\_  
(c) City or town \_\_\_\_\_ (If outside city or town limits, write "RURAL")  
(d) Street No. \_\_\_\_\_ (If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Ray Underheid  
3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex m 5. Color w 6. (a) Single, widowed, married, divorced \_\_\_\_\_  
6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased Aug (Month) 19 (Day) 19 (Year)

8. AGE: Years \_\_\_\_\_ Months \_\_\_\_\_ Days \_\_\_\_\_ (If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.)

9. Birthplace \_\_\_\_\_ (City, town, or county) \_\_\_\_\_ (State or foreign country)

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

MOTHER FATHER

12. Name \_\_\_\_\_  
13. Birthplace \_\_\_\_\_ (City, town, or county) \_\_\_\_\_ (State or foreign country)  
14. Maiden name \_\_\_\_\_  
15. Birthplace \_\_\_\_\_ (City, town, or county) \_\_\_\_\_ (State or foreign country)

16. (a) Informant \_\_\_\_\_

(b) Address \_\_\_\_\_

17. (a) \_\_\_\_\_ (Burial, cremation, or removal) (b) Date thereof \_\_\_\_\_ (Month) (Day) (Year)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

19. (a) \_\_\_\_\_ (Date received local registrar) (b) \_\_\_\_\_ (Registrar's signature)

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month \_\_\_\_\_ Year \_\_\_\_\_ Hour \_\_\_\_\_ Minute \_\_\_\_\_ M.  
21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_; to \_\_\_\_\_, 19\_\_\_\_; that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_; and that death occurred on the date and hour stated above. Immediate cause of death \_\_\_\_\_

Due to \_\_\_\_\_  
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) Acc. V

(b) Date of occurrence 7-2-78

(c) Where did injury occur? home (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 or place) (e) Means of injury \_\_\_\_\_

23. Signature Jackson (M. D. or other) MD  
Address 634 N. Grand Date signed 8/1/78

SUPPLEMENTARY

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

Duration \_\_\_\_\_  
PHYSICIAN \_\_\_\_\_  
Underline the cause to which death should be charged statistically.

S-24907