

**STANDARD CERTIFICATE OF DEATH**

36994

FILED OCT 23 1953

State File No. ....

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **9581**

<b>1. PLACE OF DEATH</b> a. COUNTY _____  b. CITY (If outside corporate limits, write RURAL and give town or township) <u>St. Louis, Mo.</u> c. LENGTH OF STAY (in this place) _____ d. FULL NAME OF HOSPITAL OR INSTITUTION <u>St. Anthony's Hospital</u>		<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Jefferson</u>  c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Imperial</u> <span style="float:right">0500, 1</span> d. STREET ADDRESS (If rural, give location) <u>Post Office Box</u>	
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<b>3. NAME OF DECEASED</b> (Type or Print) <u>Robert L. Aveyard</u> a. (First) _____ b. (Middle) _____ c. (Last) _____			<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <u>Oct. 6, 1953</u>				
<b>5. SEX</b> <u>male</u>	<b>6. COLOR OR RACE</b> <u>white</u>	<b>7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED</b> (Specify) <u>married</u>	<b>8. DATE OF BIRTH</b> <u>Aug. 26, 1882</u>	<b>9. AGE</b> (In years last birthday) <u>71</u>	<b>IF UNDER 1 YEAR</b> Months _____ Days _____	<b>IF UNDER 4 HRS.</b> Hours _____ Min. _____	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>retired Asst. Postmaster</u>			<b>10b. KIND OF BUSINESS OR INDUSTRY</b> _____		<b>11. BIRTHPLACE</b> (City and State or Foreign Country) <u>St. Louis, Mo.</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> _____

<b>13a. FATHER'S NAME</b> <u>Robert B. Aveyard</u>	<b>13b. MOTHER'S MAIDEN NAME</b> <u>Mary Constant</u>	<b>14. NAME OF HUSBAND OR WIFE</b> <u>Lillian Aveyard</u>
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>	<b>16. SOCIAL SECURITY NO.</b> <u>no</u>	<b>17. INFORMANT'S SIGNATURE OR NAME</b> ADDRESS <u>Mrs. Lillian Aveyard, Beck, Mo.</u>

<b>18. CAUSE OF DEATH</b> Enter only one cause per line for (a), (b), and (c)  *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.	<b>MEDICAL CERTIFICATION</b> <b>I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*</b> (a) <u>Bronchopneumonia, both lungs (with fluid)</u> <b>ANTECEDENT CAUSES</b> Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. <u>xxxxxx Complication: Acute nephritis</u> DUE TO (b) _____ DUE TO (c) _____  <b>II. OTHER SIGNIFICANT CONDITIONS</b> Conditions contributing to the death but not related to the disease or condition causing death.	<b>INTERVAL BETWEEN ONSET AND DEATH</b> <u>6 days</u>  <u>6 "</u>
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<b>19a. DATE OF OPERATION</b>	<b>19b. MAJOR FINDINGS OF OPERATION</b>	<b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
<b>21a. ACCIDENT SUICIDE HOMICIDE</b> (Specify)	<b>21b. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)	<b>21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)</b>
<b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (Min.)	<b>21e. INJURY OCCURRED WHILE AT WORK</b> <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	<b>21f. HOW DID INJURY OCCUR?</b> <u>590X</u>

22. I hereby certify that I attended the deceased from Oct. 2, 1953, to Oct. 6, 1953, that I last saw the deceased alive on Oct. 6, 1953, and that death occurred at 1230a m., from the causes and on the date stated above.

<b>23a. SIGNATURE</b> (Degree or title) <u>A. W. Peters M.D.</u>	<b>23b. ADDRESS</b> <u>4145 a S. Grand Blvd.</u>	<b>23c. DATE SIGNED</b> <u>10/6/53</u>
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<b>24a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Removal</u>	<b>24b. DATE</b> <u>10-8-53</u>	<b>24c. NAME OF CEMETERY OR CREMATORY</b> <u>St. Trinity Lutheran</u>	<b>24d. LOCATION</b> (City, town, or county) (State) <u>Lemay, Mo.</u>
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<b>DATE REC'D BY LOCAL REG.</b> <u>OCT 6 1953</u>	<b>REGISTRAR'S SIGNATURE</b> <u>Carl Smith Mo</u>	<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> ADDRESS <u>Southern Funeral Home</u> <u>6322 S. Grand Blvd.</u>
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(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING INK—ON FRONT SIDE

Dr Peters  
4145 Grand  
St W 4

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 \_\_\_\_\_

Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student .....  
Student Embalmer

Signed

*David H. Johnson*

Licensed Embalmer No. *4244*

P. O. Address *6322 S. Grand*

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.