

# THE DIVISION OF HEALTH OF MISSOURI STANDARD CERTIFICATE OF DEATH

State File No. **21603**

BIRTH NO. _____		REG. DIST. NO. <b>310</b>		PRIMARY REG. DIST. NO. <b>3058</b>		Registrar's No. <b>157</b>	
1. PLACE OF DEATH a. COUNTY <b>St. Charles</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>St. Louis</b>			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>St. Charles</b>				c. CITY OR TOWN <b>Robertson</b>		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>St. Joseph Hospital</b>				e. STREET ADDRESS (If rural, give location) <b>Taussig Ave. R#2-Box 240</b>			
3. NAME OF DECEASED (Type or Print)		a. (First) <b>Louis</b>		b. (Middle) <b>Aubuchon</b>		c. (Last) _____	
4. DATE OF DEATH		(Month) <b>June</b>		(Day) <b>8</b>		(Year) <b>1956</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Widowed</b>	8. DATE OF BIRTH <b>Feb. 10, 1870</b>		9. AGE (In years last birthday) <b>86</b>	10. IF UNDER 1 YEAR Months <b>3</b> Days <b>28</b>	11. IF UNDER 1 HR. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farming</b>		11. BIRTHPLACE (City and State or Foreign Country) <b>Florissant, Mo.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13a. FATHER'S NAME <b>Batiste Aubuchon</b>		13b. MOTHER'S MAIDEN NAME <b>Leonor Lajeunesse</b>		14. NAME OF HUSBAND OR WIFE <b>Mabel Ded.</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT'S SIGNATURE OR NAME <b>Manuel Aubuchon</b> ADDRESS <b>Robertson, Mo. R#2</b>			
18. CAUSE OF DEATH 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.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Urinary</b>  ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <b>Fracture of Hip</b> DUE TO (c) <b>Arteriosclerosis</b>  II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <b>Fracture Hip</b>				INTERVAL BETWEEN ONSET AND DEATH <b>4 days</b>  <b>7 days</b>  <b>?</b>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION <b>45</b>				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <b>June 7 1956 7 PM</b>		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? <b>Fell from porch steps</b>			
22. I hereby certify that I attended the deceased from <b>June 2, 1956</b> , to <b>June 8, 1956</b> , that I last saw the deceased alive on <b>June 8, 1956</b> , and that death occurred at <b>9 P. M.</b> , from the causes and on the date stated above.							
23a. SIGNATURE <b>[Signature]</b> (Degree or title)				23b. ADDRESS <b>St. Charles Mo.</b>		23c. DATE SIGNED <b>June 9, 1956</b>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		24b. DATE <b>6-11-1956</b>		24c. NAME OF CEMETERY OR CREMATORY <b>St. Ferdinand Cemetery</b>		24d. LOCATION (City, town, or county) (State) <b>Florissant, Mo.</b>	
DATE REC'D BY LOCAL REG <b>June 10 1956</b>		REGISTRAR'S SIGNATURE <b>[Signature]</b>		25. MEDICAL DIRECTOR'S SIGNATURE <b>[Signature]</b> ADDRESS <b>2504-Woodson Rd-Overland, Mo.</b>			

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

FILED JUN 18 1956

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**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.....  
Signature of Student Embalmer

Signed *Oscar F Mueller*.....

Licensed Embalmer No. *3039*

P. O. Address *Overland*.....

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.