

FILED JUL 13 1959

THE DIVISION OF HEALTH OF MISSOURI  
 STANDARD CERTIFICATE OF DEATH

59-022650  
 STATE FILE NUMBER

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar No. **6051**

300  
 1-57

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1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <b>St. Louis</b>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>St. Louis City Hospital</b>			Length of stay in 1b		d. STREET ADDRESS <b>3711 McDonald Ave.</b>		(If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Richard B. Aubuchon</b>				4. DATE OF DEATH Month Day Year <b>June 25, 1959</b>				
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Jan. 7, 1894</b>		9. AGE (In years loss birthday) <b>65</b>	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Salesman</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Carlton Company</b>		11. BIRTHPLACE (City and state or country) <b>Crystal City, Mo.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13a. FATHER'S NAME <b>David Aubuchon</b>			13b. MOTHER'S MAIDEN NAME <b>Mary Glaze</b>			14. NAME OF HUSBAND OR WIFE <b>Anna C. Aubuchon</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war, dates of service) <b>yes W.W. #1</b>			16. SOCIAL SECURITY NO. <b>188-03-3234</b>		17. INFORMANT Address <b>Anna C. Aubuchon - 3711 McDonald Ave.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute pulmonary edema</b> <b>accounted for by recent traumatic</b> <b>cervical lacerations and</b> <b>tracheotomy.</b> Conditions, if any, DUE TO (b) <b>E977X</b> which gave rise to above cause (a), stating the underlying cause last. DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Following self inflicted wounds of forehead in Home on June 22, 1959.</b>							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT <input type="checkbox"/>	SUICIDE <input checked="" type="checkbox"/>	HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter signature of injurer in PART I or PART II if in 18b) <b>Wounds of forehead in Home on June 22, 1959.</b>					
20c. TIME OF INJURY Hour a.m. Month, Day, Year p.m. <b>6:22:59</b>		20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>Home</b>		20f. CITY, TOWN, OR LOCATION COUNTY STATE <b>St. Louis Mo</b>		
21. I attended the deceased from _____ to _____ and last saw her alive on _____ Death occurred at <b>1240 P</b> m on the date stated above; and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE <b>Paul Johnson Corcoran</b>			22b. ADDRESS <b>1300 Clark</b>		22c. DATE SIGNED <b>6/26/59</b>			
23a. BURIAL, CREATION, REMOVAL (Specify) <b>Removal</b>		23b. DATE <b>June 29, 1959</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Sunset Burial Park</b>		23d. LOCATION (City, town, or county) (State) <b>St. Louis County, Missouri</b>			
24. FUNERAL DIRECTOR ADDRESS <b>WACKER-HELDERLE-3634 Gravois Ave.</b>				25. DATE RECD. BY LOCAL REG. <b>JUN 26 59</b>		26. REGISTRAR'S SIGNATURE <b>Loan Smith, M.D.</b>		

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

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 John J. Krupinski  
Licensed Embalmer No. 3497  
P. O. Address St. Louis

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.