

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS MAY 31 1960

=60-021774

INDEXED

STATE FILE NUMBER

Registration District No. 317 Primary Registration District No. 541 Registrar's No. 1578

| | | | |
|---|--|---|--|
| 1. PLACE OF DEATH a. COUNTY <u>St. Louis</u> | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> COUNTY <u>St. Louis</u> | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Clayton</u> | | Length of stay in 1b <u>12 day's</u> | c. CITY OR TOWN <u>Florissant</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>St. Louis County Hosp.</u> | | Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | d. STREET ADDRESS (If outside, give location) <u>1171 St. Michael Dr.</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |

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|--|-------------------------------|--|--|---|---|---|
| 3. NAME OF DECEASED (Type or print) First <u>Augustine</u> Middle <u>Aubuchon</u> Last <u></u> | | | 4. DATE OF DEATH Month <u>5</u> Day <u>15</u> Year <u>60</u> | | | |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>White</u> | 7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH <u>8-30-74</u> | 9. AGE (last birthday) <u>85</u> | IF UNDER 1 YEAR Months <u></u> Days <u></u> | IF UNDER 24 HR Hours <u></u> Min. <u></u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>None</u> | | 11. BIRTHPLACE (City and state or country) <u>Florissant, Mo.</u> | | 12. CITIZEN OF WHAT COUNTRY <u>U.S.A</u> |
| 13a. FATHER'S NAME <u>Alex De Hatre</u> | | 13b. MOTHER'S MAIDEN NAME <u>Josephine Roy</u> | | 14. NAME OF HUSBAND OR WIFE <u>Peter Aubuchon</u> | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u></u> | | 16. SOCIAL SECURITY NO. <u></u> | | 17. INFORMANT Address <u>Peter Aubuchon 1171 St. Mich</u> | | |

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|---|--|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: | | INTERVAL BETWEEN ONSET AND DEATH |
| IMMEDIATE CAUSE (a) <u>Massive Pulmonary Embolus Probable</u> | | |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. | | |
| DUE TO (b) <u>Thrombosis left femoral vein</u> | | |
| DUE TO (c) <u>Septic hip joint</u> | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) | | PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown |

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|--|---|--|---|
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/> | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) | |
| 20c. TIME OF INJURY Hour <u></u> a.m. <u></u> p.m. <u></u> Month, Day, Year <u></u> | 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.) | 20f. CITY, TOWN, OR LOCATION COUNTY STATE |

21. I attended the deceased from 5-3-60 to 5-15-60 and last saw her alive on 5-15-60
 Death occurred at 4:30 a.m. on the date stated above, and to the best of my knowledge, from the causes stated.

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|---|--------------------------|--|--|---------------------------------|
| 22a. SIGNATURE (Degree or title) <u>Helene R. Hunt M.D.</u> | | 22b. ADDRESS <u>601 So. Brentwood</u> | | 22c. DATE SIGNED <u>5-15-60</u> |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 23b. DATE <u>5-18-60</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>St. Ferdinand Cem.</u> | 23d. LOCATION (City, town, or county) (State) <u>Florissant, Mo.</u> | |
| 24. FUNERAL DIRECTOR ADDRESS <u>White-Mullen Mortuary</u> | | 25. DATE RECD. BY LOCAL REG. <u>5-16-60</u> | 26. REGISTRAR'S SIGNATURE <u>John B. Mungley</u> | |

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by _____
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed _____

Licensed Embalmer No. _____

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

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