

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

3115-62-012424
STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. _____

FILED APR 6 1962

VS 300
Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY		b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN		Length of stay in 1b		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE		b. COUNTY		c. CITY OR TOWN		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>					
		St. Louis, Mo.				Mo.		St. Louis		Overland		Yes <input type="checkbox"/> No <input type="checkbox"/>					
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION				Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location)						Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>					
Firmin Desloge Hospital						3326 Eminence											
3. NAME OF DECEASED (Type or print)			First			Middle			Last			4. DATE OF DEATH					
Frank			L.			Aubuchon			March			21, 1962					
5. SEX		6. COLOR OR RACE		7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HR					
Male		White				11/24/1865		96		Months		Days					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (City and state or country)				12. CITIZEN OF WHAT COUNTRY					
Retired Metal Lather								Florissant, Mo.				U.S.A.					
13a. FATHER'S NAME				13b. MOTHER'S MAIDEN NAME				14. NAME OF HUSBAND OR WIFE									
Louis Aubuchon				Adeline Creely				Lillie Brady Aubuchon									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.				17. INFORMANT				Address					
No.				Nil.				None				Mrs. Grace A. Johnson, 715 Edgemont Lane Park Ridge, Illinois					
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)												Week					
Influenza																	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.												yrs					
and (b)																	
Generalized Arteriosclerosis																	
and (c)												yrs					
Nephrosclerosis 481x																	
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.							
Arteriosclerotic Heart Disease, Complete Heart Block										<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT		SUICIDE		HOMICIDE		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in PART I or PART II of item 18.)									
20c. TIME OF INJURY		Hour		Month, Day, Year		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			
		a.m. p.m.															
21. I attended the deceased from				to				and last saw him alive on									
3/14/62				3/21/62				3/21/62									
Death occurred at				m on the date stated above, and to the best of my knowledge, from the causes stated.													
3:05 P.M.																	
22a. SIGNATURE (Degree or title)						22b. ADDRESS						22c. DATE SIGNED					
Masao Okamoto M.D.						607 N. Grand, St. Louis 3, Mo						3/22/62					
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City, town, or county)			(State)					
Removal			3-22-62			Fee Fee Cemetery			St. Louis County, Mo.								
24. FUNERAL DIRECTOR						25. DATE RECD. BY LOCAL REG.						26. REGISTRAR'S SIGNATURE					
Albert H. Hoppe Inc., 4700 Washington, Blvd						MAR 22 1962						Karl Smith, M.D.					

USE BLACK INK OR TYPEWRITER RIBBON

DOCUMENT

MEDICAL CERTIFICATION

MAR 22 1962

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 Melvin L. Kemper

Licensed Embalmer No. 4052

P. O. Address 4911 Washington
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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.