

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

=62-020138

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. **318**

Primary Registration District No. **1003**

Registrar's No. **5461**

FILED JUN 7 1962

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Rev. 4/59

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USE BLACK INK OR TYPEWRITER RIBBON

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY <b>St. Louis</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, give TOWNSHIP only) OR TOWN <b>St. Louis</b>		Length of stay in lb <b>1 day</b>	c. CITY OR TOWN <b>Florissant</b> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>St. John's Hospital</b>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>990 St. Francois St.</b> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <b>HENRY LEON AUBUCHON</b>			4. DATE OF DEATH Month Day Year <b>May 29, 1962</b>
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>5-26-1902</b>
9. AGE (last birthday) <b>60</b>		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Bus Driver</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>SL Public Service</b>	11. BIRTHPLACE (City and state or country) <b>Ferguson, Mo.</b>
12. CITIZEN OF WHAT COUNTRY <b>USA</b>		13a. FATHER'S NAME <b>Leon Aubuchon</b>	
13b. MOTHER'S MAIDEN NAME <b>Mary Isabelle Aubuchon</b>		14. NAME OF HUSBAND OR WIFE <b>Deceased</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>[Redacted]</b>	
17. INFORMANT <b>Mrs. Eunice Foeller, 749 St. Charles</b>		Address <b>Florissant, Mo.</b>	
18. CAUSE OF DEATH (Enter only one cause per line PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac decompensation</b>			INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>Hypertensive cardiovascular disease</b>			<b>1 year</b>
DUE TO (c) <b>443X</b>			
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 type="checkbox"/> No <input type="checkbox"/> Unknown
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT / SUICIDE / HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <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 a.m. p.m. 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 <b>September 1961 to 5-29-62</b>		COUNTY STATE
21. I attended the deceased from <b>5:50 a:</b> m on the date stated above, and to the best of my knowledge, from the causes stated.		and last saw him alive on <b>5-28-1962</b>	
22a. SIGNATURE (Degree or title) <b>Ervin Ben Leards, M.D.</b>		22b. ADDRESS <b>11670 Gravois, St. Louis 26</b>	22c. DATE SIGNED <b>5-31-62</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	23b. DATE <b>6-1-62</b>	23c. NAME OF CEMETERY OR CREMATORY <b>St. Ferdinand</b>	23d. LOCATION (City, town, or county) (State) <b>Florissant, Mo.</b>
24. FUNERAL DIRECTOR <b>The Florissant Mortuary, Florissant, Mo.</b>		ADDRESS	25. DATE RECD. BY LOCAL REG. <b>MAY 31 1962</b>
		26. REGISTRAR'S SIGNATURE <b>Earl Smith, M.D.</b>	

**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 Gene Whitcomb

Licensed Embalmer No. 4966

P. O. Address Florissant, 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.