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17-39
X23159

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

36302

STANDARD CERTIFICATE OF DEATH

State File No. _____

Registration District No. _____

Primary Registration District No. 101

Registrar's No. 2049

FILED NOV 25 1940
784

1. PLACE OF DEATH:

(a) County St. Louis

(b) City or town Clayton
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: St. Louis County Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 2 days
(Specify whether

In this community life
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County St. Louis

(c) City or town Wellston
(If outside city or town limits, write "RURAL")

(d) Street No. 1665 Lulu Ave.
(If rural, give location)

(e) If foreign born, how long in U. S. A.? _____ years.

3. (a) PRINT FULL NAME Thomas Albert Audrain

3. (b) If veteran, name war unknown

3. (c) Social Security No. unknown

4. Sex male 5. Color or race white

6. (a) Single, widowed, married, divorced married

6. (b) Name of husband or wife _____

6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased Sept. 22 1878
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>62</u>	<u>1</u>	<u>8</u>	hr. _____ min. _____

9. Birthplace Portage Mo.
(City, town, or county) (State or foreign country)

10. Usual occupation nil

11. Industry or business _____

12. Name Thomas Bud Audrain

13. Birthplace St. Charles Mo.
(City, town, or county) (State or foreign country)

14. Maiden name Margaret Sersenberger

15. Birthplace St. Charles Mo.
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Audrain

(b) Address Wellston

17. (a) _____ (b) Date thereof 10 2 1940
(Burial, cremation, or other) (Month) (Day) (Year)

(c) Place: burial or cremation Calvary Cemetery

18. (a) Signature of funeral director Clark Funeral Home

(b) Address 1125 Hadjiament Ave

19. (a) OCT 31 1940 (b) D. R. Myers M.D.
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct. day 30
year 1940 hour 1 minute :30 A.M.

21. I hereby certify that I attended the deceased from 10-28-40
_____, 19____, to 10-30-40, 19____;
that I last saw him alive on 10-30-40, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death Coronary Occlusion Duration 2 da.

Due to Hypertensive cardio-vascular disease. 6 month

Due to 95 & 2

Other conditions (Include pregnancy within 3 months of death) _____

Major findings: Of operations _____

Of autopsy _____

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

(c) Where did injury occur? _____
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____
(Specify type of place) (e) Means of injury.

23. Signature H. H. Faour Jr. (M. D. or _____)
Address Co. Hwy Date signed 10/30/40

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

MOTHER FATHER

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.....
....., Registered Apprentice No.....
working under my personal supervision.

Signed.....

Alan Kelly

Licensed Embalmer No.....

3025

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