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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

25392

State File No.

FILED SEP 14 1945

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 7876

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

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1. PLACE OF DEATH:
(a) County
(b) City or town St. Louis, Missouri. (If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: St. Louis City Hospital-Max C. Starkloff Memorial (If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution (Specify whether years, months or days)
In this community

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County 000
(c) City or town St. Louis (If outside city or town limits, write "RURAL") 17
(d) Street No. 5½ South Broadway (If rural, give location) 9
(e) Citizen of foreign country? 0 (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Otto Aude
3. (b) If veteran, name war Unknown
3. (c) Social Security No. Unknown
4. Sex Male 0
5. Color or race White
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Ida Aude
6. (c) Age of husband or wife if alive 75 years
7. Birth date of deceased April (Month) 14, (Day) 1865 (Year)

8. AGE: Years 80 Months 4 Days 14 If less than one day hr. min.

9. Birthplace St. Louis, (City, town, or county) Missouri 0 (State or foreign country)
10. Usual occupation Retired Furniture Dealer
11. Industry or business

FATHER
12. Name Unknown Unknown
13. Birthplace Unknown (City, town, or county) Unknown 0 (State or foreign country)

MOTHER
14. Maiden name Unknown Unknown
15. Birthplace Unknown (City, town, or county) Unknown 0 (State or foreign country)

16. (a) Informant Mrs. Ida Aude
(b) Address 3917 a Botanical Ave.
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/8/45 (Month) (Day) (Year)
(c) Place: burial or cremation Bellefontaine Cemetery
18. (a) Signature of funeral director Albert H. Hoppe
(b) Address 4700 Washington Blvd.
19. (a) SEP 8 1945 (Date received local registrar) (b) [signature] (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug. day 28th year 1945 hour 12:30 minute P. M.
21. I hereby certify that I attended the deceased from 8/3/45, 19..., to 8/28/45, 19...; that I last saw him alive on 8/28/45, 19...; and that death occurred on the date and hour stated above.

Immediate cause of death Generalized arteriosclerosis — Duration

Due to

Due to

Other conditions
* (Include pregnancy within 3 months of death) 97

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? (Specify type of place)
While at work? (e) Means of injury 0
23. Signature Herbert C. Fritz (M. D. or other)
Address 1515 Lafayette 8/28/45

(Licensed Embalmer's Statement on Reverse Side)

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 Albert G. Hoyge

Licensed Embalmer No. 2971

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.