

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

FILED APR 3 1947

State File No. 0

Registration District No. 3

Primary Registration District No. 3063

Registrar's No. 756

1. PLACE OF DEATH:

(a) County **St. Louis County**

(b) City or town **Clayton, Missouri**  
(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 Mo. 22 da**  
(Specify whether years, months or days)

In this community **20 years**  
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **St. LOUIS** 96

(c) City or town **Webster Groves** 7  
(If outside city or town limits, write "RURAL.") 4

(d) Street No. **732 Greeley Avenue**  
(If rural, give location) 1

(e) Citizen of foreign country? **No** (Yes or No)

If yes, name country.....

3. (a) PRINT FULL NAME **Robert Aude**

3. (b) If veteran, name war **No**

3. (c) Social Security No **497-01-0785**

MEDICAL CERTIFICATION

20. DATE OF DEATH, Month **March** day **30th**  
year **1947** hour **12** minute **10** a.M.

21. I hereby certify that I attended the deceased from **January 8th**, 19**47**, to **March 30th**, 19**47**  
that I last saw h **im** alive on **March 30th**, 19**47**  
and that death occurred on the date and hour stated above.

4. Sex **Male** 5. Color or race **White**

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

6. (b) Name of husband or wife **Adele Aude**

6. (c) Age of husband or wife if alive **1884** years

7. Birth date of deceased **July 7** **1884**  
(Month) (Day) (Year)

Immediate cause of death **Coronary occlusion** Duration

8. AGE: Years **62** Months **8** Days **23**  
If less than one day hr. min.

Due to **arteriosclerosis, generalized**

9. Birthplace **St. Louis, Missouri**  
(City, town, or county) (State or foreign country)

Due to **MI**

10. Usual occupation **Accountant**

Other condition **Branchitis, chronic**  
(Include pregnancy within 3 months of death)

11. Industry or business

12. Name **Daniel Aude**

13. Birthplace **Hamburg Germany** 4  
(City, town, or county) (State or foreign country)

14. Maiden name **Caroline Peters**

15. Birthplace **Germany** 6  
(City, town, or county) (State or foreign country)

Major findings: **of prostate; cerebral thrombosis** PHYSICIAN

Of operations

Of autopsy

Underline the cause to which death should be charged statistically.

16. (a) Informant **Adele Aude, wife** 7

(b) Address **732 Greeley Ave, Webster**

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?

17. (a) **BURIAL** (b) Date thereof **APRIL-6-1947**  
(Burial, cremation, or removal) (Month) (Day) (Year)

(Specify type of place) (c) Means of injury

(c) Place: burial or cremation **ZION CEMETERY**

18. (a) Signature of funeral director **Parker Lindes**

While at work? (Specify type of place) (c) Means of injury

(b) Address **WEBSTER GROVES, MO.**

19. (a) **4-3-47** (b) **Beeth of St. Louis**  
(Date received local registrar) (Registrar's signature)

23. Signature **Wm. C. Citchlow** (M. D. or other)

Address **601 S. Brentwood** Date signed **3-30-47**

**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.....

*Leslie Welch*

Licensed Embalmer No. *4395*

P. O. Address *Robster Groves*

**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.**