

No. 3000
-10-47
5-17-39
W I 3905

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

13829
10529
State File No. _____
Registrar's No. **3725**

FILED APR 30 1948
Registration District No. **318**

Primary Registration District No. **1003**

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

1. PLACE OF DEATH:

(a) County **St. Louis**

(b) City or town **St. Louis**
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: **3534 Illinois /**
(If not in hospital or institution, write street number or location)

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

In this community _____
years, months or days

3. (a) PRINT FULL NAME **August Aurin**

3. (b) If veteran, _____ **3. (c) Social Security No.** _____
name war

4. Sex **Male** **5. Color or race** **White** **6. (a) Single, widowed, married** **Widowed**
divorced

6. (b) Name of husband or wife **Minnie Aurin** **6. (c) Age of husband or wife if** _____
alive _____ years

7. Birth date of deceased **January 14, 1858**
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
90	0	4	hr. _____ min. _____

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

10. Usual occupation **Retired**

11. Industry or business _____

12. Name **Don't Know**

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

14. Maiden name **Don't Know**

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

16. (a) Informant **Mrs. B. Nickolus**

(b) Address **2445 Bremerton Rock Hill**

17. (a) Burial **(b) Date thereof** **4-21-48**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **New St. Marcus Cemetery**

18. (a) Signature of funeral director **Weick Bro. Und. Co.**

(b) Address **2201 S. Grand Bl.**

19. (a) APR 20 1948 **J. F. Braseck**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **o-o-o**

(c) City or town **St. Louis**
(If outside city or town limits, write "RURAL")

(d) Street No. **3534 Illinois Ave.**
(If rural, give location)

(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **April** day **18**
year **1948** hour **3** minute **15P** M.

21. I hereby certify that I attended the deceased from **Jan 7** 19 **45** to **Apr 18** 19 **48**
and that death occurred on the date and hour stated above **19 48**

that I last saw him alive on **April 18** 19 **48**

Immediate cause of death: **Gastro-enteritis** **Duration** **3 days**

Due to _____

Due to _____

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

Major findings:
Of operations _____

Of autopsy _____

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)
(a) Means of injury _____

23. Signature **Leroy Ellison MD** (M. D. or other)

Address **3610 So. Broadway** Date signed **4-19-48**

PHYSICIAN

Underline the cause to which death should be charged statistically.

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..... *Delix J. Kuspis*

..... Licensed Embalmer No. *3497*

P. O. Address. *2201 S Grand.*

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.