FILED JUL 13 1951

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 21648

BIRTH NO. _____ REG. DIST. NO. 3,7 PRIMARY REG. DIST. NO. 6076 Registrar's No. 2555

1. PLACE OF DEATH
a. COUNTY: ST. LOUIS
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): CARSONVILLE
c. LENGTH OF STAY (In this place): 19 mos.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): PENNS HOME

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: MISSOURI
b. COUNTY: St. LOUIS
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): FLORISSANT 4050
d. STREET ADDRESS (If rural, give location): R. #2 - Howdershell Rd.

3. NAME OF DECEASED (Type or Print)
a. (First): GEORGE
b. (Middle):
c. (Last): AUBUCHON

4. DATE OF DEATH (Month) (Day) (Year): JUNE 30 1951

5. SEX: M
6. COLOR OR RACE: W
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): N. MARRIED
8. DATE OF BIRTH: UNKNOWN
9. AGE (In years last birthday): about 85 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): FARMER
10b. KIND OF BUSINESS OR INDUSTRY: OWN
11. BIRTHPLACE (State or foreign country): FLORISSANT, MO.
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13a. FATHER'S NAME: JOSEPH AUBUCHON
13b. MOTHER'S MAIDEN NAME:
14. NAME OF HUSBAND OR WIFE: NONE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO — (If yes, give war or dates of service): NONE
16. SOCIAL SECURITY NO.: NONE
17. INFORMANT'S SIGNATURE OR NAME — ADDRESS

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Cerebral hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 1 day

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Arteriosclerosis — 5 years
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION: 3.31 X
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Nov 1, 1949, *to* June 30, 1951, *that I last saw the deceased alive on* June 26, 1951, *and that death occurred at* 10 A *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Lewis Littmann MD.
23b. ADDRESS: 8231 Clayton Rd (17)
23c. DATE SIGNED: 7/2/51

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 7-2-1951
24c. NAME OF CEMETERY OR CREMATORY: St. Ferdinand Cem
24d. LOCATION (City, town, or county) (State): Florissant, Mo.

DATE REC'D BY LOCAL REG.: 7-2-51
REGISTRAR'S SIGNATURE: Herbert R. Domke M.D.
25. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: Baumann Bros Inc. Overland, Mo.

(Licensed Embalmer's Statement on Reverse Side)

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

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 me

.....,

working under my personal supervision.

Student Embalmer No.....

Signed Oscar F. Mueller

Signed.....
Student Embalmer

Licensed Embalmer No. 3039

P. O. Address Overland M

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply w the above constitutes grounds for revocation of license.)

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