

FILED NOV 22 1957

STANDARD CERTIFICATE OF DEATH

41699

STATE FILE NUMBER

Registration District No. 318 Primary Registration District No. 1003

Registrar's No. 10928

S. 300  
1-57

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Louis</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>St. Louis</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>DePaul Hospt.</u>			Length of stay in 1b	d. STREET ADDRESS (If outside, give location) <u>2208 2725 Dodier St.</u>			Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Jasper</u> Middle <u>J.</u> Last <u>AuBuchon</u>				4. DATE OF DEATH Month <u>11</u> Day <u>13</u> Year <u>57</u>				
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>7/29/1885</u>		9. AGE (In years last birthday) <u>72</u>	10. F UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Carter Carbure.</u>		11. BIRTHPLACE (City and state or country) <u>French Village Mo.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13a. FATHER'S NAME <u>Louis AuBuchon</u>			13b. MOTHER'S MAIDEN NAME <u>Mary Lucy Boyer</u>		14. NAME OF HUSBAND OR WIFE <u>Clara AuBuchon</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No.</u>			16. SOCIAL SECURITY NO. <u>198-10-2322</u>	17. INFORMANT Address <u>Mrs. AuBuchon 2725 Dodier St.</u>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of prostate</u>						INTERVAL BETWEEN ONSET AND DEATH <u>2 years</u>		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) _____ DUE TO (c) _____								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a).						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) <u>177x</u>					
20c. TIME OF INJURY Hour _____ a.m. _____ p.m. Month, Day, Year _____								
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION			COUNTY	STATE
21. I attended the deceased from <u>June 9 55</u> to <u>November 13</u> and last saw her alive on <u>11-13-57</u> Death occurred at <u>10 P.</u> m on the date stated above; and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE <u>H.H. Keller</u> (Degree or title) <u>H. H. Keller M.D.</u>				22b. ADDRESS <u>2739 No. Grand</u>			22c. DATE SIGNED <u>11-15-57</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		23b. DATE <u>11/16/57</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Desloge Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Desloge Mo.</u>			
24. FUNERAL DIRECTOR <u>Robert D. Kinealy 2228 St. Louis Ave.</u>				25. DATE RECD. BY LOCAL REG. <u>NOV 15 57</u>		26. REGISTRAR'S SIGNATURE <u>Carl Smith</u>		

(Licensed Embalmer's Statement on Reverse Side)

Doctor; coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

Carolina State Board of Health

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 ....., Student Embalmer No. .... working under my personal supervision.

Student .....  
Signature of Student Embalmer

Signed *Homer W. Lutz* .....

Licensed Embalmer No. *3982*  
P. O. Address *St Louis Mo*

DIR. OF HEALTH

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.