

**JURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**

'59 0 4 5 2 0 3

**FILED VS JAN - 4 1960**

**211680**

STATE FILE NUMBER

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MISSOURI</b> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>ST LOUIS</b>		Length of stay in 1b	c. CITY OR TOWN <b>ST LOUIS,</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>NEWSTEAD &amp; LEE</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>4385 SACRAMENTO AVE</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <b>FRANK</b> Middle <b>AUBUCHON</b> Last <b>AUBUCHON</b>			4. DATE OF DEATH Month <b>DEC,</b> Day <b>14,</b> Year <b>1959</b>		
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>DEC. 15, 1887</b>	9. AGE (last birthday) <b>77</b>	IF UNDER 1 YEAR Months _____ Days _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED PACKING HOUSE</b>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <b>FLORISSANT MISSOURI</b>	12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>	

13a. FATHER'S NAME <b>ELLIOT AUBUCHON</b>	13b. MOTHER'S MAIDEN NAME <b>LOUISE DUBRAY</b>	14. NAME OF HUSBAND OR WIFE <b>ADDIE AUBUCHON</b>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>NO</b>	16. SOCIAL SECURITY NO. <b>490-03-5762</b>	17. INFORMANT Address <b>ADDIE AUBUCHON 4335 SACRAMENTO AVE</b>

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>Dec 14-59</b> <i>unable to say.</i>
CONDITIONS, IF ANY, WHICH GAVE RISE TO ABOVE CAUSE (b) <b>Coronary heart disease</b> STATE THE UNDERLYING CAUSE (c)		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal (disease condition given in PART I (a)) <b>420.1</b>		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
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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.)	
20c. TIME OF INJURY Hour _____ Month, Day, Year _____ a.m. _____ p.m. _____	20d. INJURY OCCURRED WHILE AT WORK <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 **Jan 15 - 57** to **Dec 14 - 59** and last saw her him alive on **Nov 6 - 59**  
Death occurred at \_\_\_\_\_ m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <b>Peter A Eck M.D.</b>	22b. ADDRESS <b>4 Medical West Bldg. St. Louis County mo</b>	22c. DATE SIGNED <b>Dec 16-59</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE <b>12/18/59</b>	23c. NAME OF CEMETERY OR CREMATORY <b>ST FERDINAND CEMETERY</b>	23d. LOCATION (City, town, or county) (State) <b>FLORISSANT MISSOURI</b>
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24. FUNERAL DIRECTOR ADDRESS <b>STROOT - CARROLL 4600 NATURAL BRIDGE</b>	25. DATE RECD. BY LOCAL REG. <b>DEC 17 1959</b>	26. REGISTRAR'S SIGNATURE <b>Harold Smith M.D.</b>
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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

Dr. Y. G. ...  
950 ...  
9 to 11 ...  
fac - 2228

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by \_\_\_\_\_  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed M W Ruster

Licensed Embalmer No. 4865

P. O. Address St Louis

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.