

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

**-61-015803**

STATE FILE NUMBER

Registration District No. 317 Primary Registration District No. 541 Registrar's No. 1026

AMENDED

DATE AMENDED

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT  
MEDICAL CERTIFICATION  
BY AFFIDAVIT OF

**FILED APR 24 1961**

1. PLACE OF DEATH  
a. COUNTY St. Louis

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)  
a. STATE Missouri COUNTY St. Louis

b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Clayton Length of stay in 1b 12Hrs.

c. CITY OR TOWN Overland Inside Limits Yes # No

c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Louis County Hosp. Inside Limits Yes # No

d. STREET ADDRESS 2519 Entity Reside on Farm Yes  No #

3. NAME OF DECEASED (Type or print) First John Middle W. Last Aulgur

4. DATE OF DEATH Month April Day 13 Year 1961

5. SEX Male 6. COLOR OR RACE White 7. Married  Never Married  Widowed #  Divorced

8. DATE OF BIRTH 11(21)82 9. AGE (last birthday) 78 IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HR

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired 10b. KIND OF BUSINESS OR INDUSTRY Fireman 11. BIRTHPLACE (City and state or country) Sweet Springs Mo. 12. CITIZEN OF WHAT COUNTRY U.S.A.

13a. FATHER'S NAME Andrew L. Aulgur 13b. MOTHER'S MAIDEN NAME Margaret L. Faris 14. NAME OF HUSBAND OR WIFE The late Gertrude Aulgur

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no 16. SOCIAL SECURITY NO. UNKNOWN 17. INFORMANT Address William A. Aulgur 9409 Corregidor

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY:  
IMMEDIATE CAUSE (a) Hypotension  
DUE TO (b) Dehydration - Starvation  
DUE TO (c) Neglect.  
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Cerebral arteriosclerosis

PART III. If deceased was female was there a pregnancy in last 90 days.  Yes  No  Unknown

19. WAS AUTOPSY PERFORMED? YES  NO  20a. ACCIDENT  SUICIDE  HOMICIDE  20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)

20c. TIME OF INJURY Hour 5:30 a.m. p.m. Month, Day, Year

20d. INJURY OCCURRED WHILE AT WORK  NOT WHILE AT WORK  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 April 12, 1961 to April 13, 1961 and last saw <sup>him</sup> him alive on April 13, 1961 death occurred at 5:30 a.m. on the date stated above, and to the best of my knowledge, from the causes stated.

21a. SIGNATURE (Degree or title) Albert L. Howe MD 21b. ADDRESS 601 S. Brentwood Blvd., Clayton, Mo. 21c. DATE SIGNED 4/13/61

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial 23b. DATE 4(15)1961 23c. NAME OF CEMETERY OR CREMATORY Lake Charles Cemetery 23d. LOCATION (City, town, or county) (State) St. Louis County, Mo.

24. FUNERAL DIRECTOR ADDRESS Collier Mortuary, St. Ann, Mo. 25. DATE RECD. BY LOCAL REG. 4-14-61 26. REGISTRAR'S SIGNATURE John C. Munfling M.D.

**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 Sheldon Collier

Licensed Embalmer No. 338

P. O. Address St Ann

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.