

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

63-029663

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 318

Primary Registration District No. 1003

Registrar's No. 8097

STATE FILE NUMBER

VS 300
Rev. 4/59

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USE BLACK INK OR TYPEWRITER RIBBON

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS INSTEAD OF

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 8097 STATE FILE NUMBER

FILED AUG 15 1963

1. PLACE OF DEATH a. COUNTY			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MO.</u> b. COUNTY <u>JEFFERSON</u>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>ST. LOUIS</u>		Length of stay in 1b	c. CITY OR TOWN <u>IMPERIAL</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>D.O.A. FRISCO HOSPITAL</u>			Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (if outside, give location) <u>R.R. # 2</u>	
3. NAME OF DECEASED (Type or print) <u>FRANK D AU BUCHON</u>			4. DATE OF DEATH	Month <u>AUGUST</u> Day <u>7</u> Year <u>1963</u>	
5. SEX <u>MALE</u>	6. COLOR, OR RACE <u>WHITE</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>OCT. 28, 1909</u>	9. AGE (last birthday) <u>53</u>	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>ENGINEER FRISCO</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>R.R.</u>	11. BIRTHPLACE (City and state or country) <u>MISSOURI</u>		12. CITIZEN OF WHAT COUNTRY <u>U-S-A</u>
13a. FATHER'S NAME <u>GEORGE AU BUCHON</u>		13b. MOTHER'S MAIDEN NAME <u>BERTHA FRANCK</u>		14. NAME OF HUSBAND OR WIFE <u>CATHERINE AU BUCHON</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>			17. INFORMANT <u>CATHERINE AU BUCHON R.R. 2 IMPERIAL MO.</u>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:					INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) <u>CORONARY OCCCLUSION</u>					<u>2 mos.</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>420.1</u>					
DUE TO (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>ARTERIO-SCLEROTIC HEART DISEASE</u>				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	
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 a.m. p.m.	Month, Day, Year				
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 <u>July 25 1963</u> to <u>August 7 1963</u> and last saw him alive on <u>August 7 1963</u> Death occurred at <u>4135 St</u> on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <u>Frank J. Smith MD</u> (Degree or title)			22b. ADDRESS <u>FRISCO HOSPITAL</u>		22c. DATE SIGNED <u>8/8/63</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u>	23b. DATE <u>AUG 12, 1963</u>	23c. NAME OF CEMETERY OR CREMATORY <u>RESURRECTION CEM.</u>	23d. LOCATION (City, town, or county) <u>ST. LOUIS CO MO</u> (State)		
24. FUNERAL DIRECTOR <u>Thomas Kutia 2906 Gravois</u> ADDRESS		25. DATE RECD. BY LOCAL REG. <u>AUG 9 1963</u>	26. REGISTRAR'S SIGNATURE <u>Roal Smith M.D.</u>		

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 Barley Thompson

Licensed Embalmer No. 4861

P. O. Address St Louis 19 Mo

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.

Dr. James G. ...
1695 J. ...
4950 ...
9101-8111
Krisco Hosp
707-2330
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