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MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **26156**

Registration District No. **775**

Primary Registration District No. **6020-A**

Registrar's No. **55**

1. PLACE OF DEATH
(a) County **St. Francois**
(b) City or town **Boone Terre Mo**
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
In this community **68 years**
years, months or days

3. (a) PRINT FULL NAME **GEORGE ANDREW AUBUCHON**
3. (b) If veteran, name war
3. (c) Social Security No. **488-16-5885**

4. Sex **Male**
5. Color or race **White**
6. (a) Single, widowed, married, divorced **Married**
6. (b) Name of husband or wife **Sophia M. Aubuchon**
6. (c) Age of husband or wife if alive **69** years
7. Birth date of deceased **Sept 24 1871**
(Month) (Day) (Year)

8. AGE: Years **68** Months **10** Days **3**
If less than one day hr. min.

9. Birthplace **French Village Missouri**
(City, town, or county) (State or foreign country)

10. Usual occupation **Retired**

11. Industry or business

12. Name **Joseph Aubuchon**

13. Birthplace **French Village Missouri**
(City, town, or county) (State or foreign country)

14. Maiden name **Mary Aubuchon**

15. Birthplace **French Village Missouri**
(City, town, or county) (State or foreign country)

16. (a) Informant **Mrs Sophia Aubuchon**
(b) Address **Boone Terre Mo**

17. (a) **Burial** (b) Date thereof **July 29 1940**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **St Joseph Cemetery Boone Terre Mo**

18. (a) Signature of funeral director **Edgar Red Co**
(b) Address **Boone Terre Mo**
19. (a) **7-29-40** (b) **N.W. Hawkins**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State **Missouri** (b) County **St. Francois**
(c) City or town **Boone Terre**
(If outside city or town limits, write "RURAL")
(d) Street No. **12 Louise**
(If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **July** day **27**
year **1940** hour **6** minute **a**.M.
21. I hereby certify that I attended the deceased from **July 26 1940** to **July 27 1940**
that I last saw him alive on **July 27 1940**
and that death occurred on the date and hour stated above.

Immediate cause of death **Acute cardiac dilatation** Duration **24 hr.**

Due to **Chronic myocarditis**

Due to _____
Other conditions (Include pregnancy within 3 months of death) **None**

Major findings: Of operations _____
Of autopsy _____
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____

(c) Where did injury occur? _____ (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? **698**
While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature **H.W. Roelke** (M. D. or other) **M.D.**
Address **Boone Terre Mo** Date signed **8-5-40**

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

4
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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.....

....., Registered Apprentice No.
working under my personal supervision.

Signed

C. J. Raywell

Licensed Embalmer No. *3706*

P. O. Address *Same Street*

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 this body is not embalmed, above space should be left blank.