

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-032662

STATE FILE NUMBER

Registration District No. 760 Primary Registration District No. 3030 Registrar's No. 117

FILED AUG 26 1963

1. PLACE OF DEATH a. COUNTY JEFFERSON b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN FESTUS Length of stay in 1b _____ c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION AT HOME Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MO b. COUNTY JEFFERSON c. CITY OR TOWN FESTUS Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> d. STREET ADDRESS (If outside, give location) 119 RICHARD, ST. Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First CLAUDE Middle J. Last AUBUCHON		4. DATE OF DEATH Month 8 Day 12 Year 63				
5. SEX MALE	6. COLOR OR RACE WHITE	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 3-29-1909	9. AGE (last birthday) 54	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) GASOLINE JOBBER		10b. KIND OF BUSINESS OR INDUSTRY GAS & OIL		11. BIRTHPLACE (City and state or country) BLACKWELL, MO.		12. CITIZEN OF WHAT COUNTRY USA
13a. FATHER'S NAME CHARLES AUBUCHON		13b. MOTHER'S MAIDEN NAME THERESA POLITTE		14. NAME OF HUSBAND OR WIFE IRENE		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) YES WW 2		16. SOCIAL SECURITY NO.		17. INFORMANT ROBERT AUBUCHON Address FESTUS, MO.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary thrombosis Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Coronary disease DUE TO (c) Generalized arteriosclerosis						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) _____				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 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>Aug 8, 1963</u> to <u>Aug 8, 1963</u> and last saw her alive on <u>Aug 8, 1963</u> Death occurred at <u>4:10 P.</u> m on the date stated above, and to the best of my knowledge, from the causes stated.						
22a. SIGNATURE <i>[Signature]</i> (Degree or title) _____		22b. ADDRESS <u>Festus, Mo.</u>		22c. DATE SIGNED <u>8/13/63</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE <u>8-14-63</u>	23c. NAME OF CEMETERY OR CREMATORY CATHOLIC CEMETERY		23d. LOCATION (City, town, or county) CRYSTAL CITY, MO. (State) _____		
24. FUNERAL DIRECTOR GENTRY R. POLITTE ADDRESS CRYSTAL CITY, MO.		25. DATE RECD. BY LOCAL REG. <u>8-13-63</u>		26. REGISTRAR'S SIGNATURE <i>[Signature]</i>		

DO NOT WRITE ON THIS STUB
 AMENDED
 DATE AMENDED
 1 0500
 2 2500
 3
 4 0
 5 1
 6
 7 0
 8 0
 9 420.1
 10
 11
 12 90-0
 13 1-0
 AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
 INSTEAD OF
 DOCUMENT
 MEDICAL CERTIFICATION
 BY AFFIDAVIT OF
 SHOULD READ
 ITEM NO.

USE BLACK INK OR TYPEWRITER RIBBON

AUG 27 1963

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 Dentry C. Felitto

Licensed Embalmer No. 3481

P. O. Address Crystal City - Mrs.

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.