MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Do not use this space.

34356

1. PLACE OF DEATH

County ..... Registration District No. 751

Township ..... Primary Registration District No. 1903

City St Louis (No. Emanuel City Hosp & St. ..... Ward)

File No. .....

Registered No. 9712

2. FULL NAME Mary L. Aubuchon

(a) Residence. No. 1068 Arsenal St. Ward. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. 6 mos. ..... ds. How long in U.S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)
Female	White	Divorced

5a. IF MARRIED, WIDOWED, OR DIVORCED
HUSBAND OF
(OR) WIFE OF Mose Aubuchon

6. DATE OF BIRTH (MONTH, DAY AND YEAR) June 1 - 1868

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
	62	4	9	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housekeeper

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9. BIRTHPLACE (CITY OR TOWN) .....
(STATE OR COUNTRY) Missouri

PARENTS

10. NAME OF FATHER Felix Labruyere

11. BIRTHPLACE OF FATHER (CITY OR TOWN) .....
(STATE OR COUNTRY) Missouri

12. MAIDEN NAME OF MOTHER Philomena Labruyere

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) .....
(STATE OR COUNTRY) Wisconsin

14. INFORMANT Mark LaBrayere

(Address) 8700 North Ave.

15. FILED OCT 11 1930 19 Mrs B Starkoff
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Oct. 10 1930

17. Ho Physician in Attendance

I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19.....

that I last saw h..... alive on ....., 19....., and that death occurred, on the date stated above, at 10:20 P. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Chronic Myocarditis

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) Chronic Nephritis

(duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED? 1270 W

IF NOT AT PLACE OF DEATH .....

DID AN OPERATION PRECEDE DEATH? ..... DATE OF .....

WAS THERE AN AUTOPSY? yes

WHAT TEST CONFIRMED DIAGNOSIS? .....

(Signed) F. W. Kemen M. D.

10/11, 1930 (Address) Dep Conn

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURIAL
Calvary Cemetery	Oct. 13 1930
20. UNDERTAKER	**ADDRESS**
Callanan Bros	1700 N Grand Blvd

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD