

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

Do not use this space.

34656

**1. PLACE OF DEATH**

County St. Louis  
Township Camden  
City St. Louis

Registration District No. 1123  
Primary Registration District No. 6248 B  
(No. Nazareth Circuit)

File No. \_\_\_\_\_  
Registered No. 394  
St. \_\_\_\_\_ Ward) \_\_\_\_\_

**2. FULL NAME**

Sister Emily Bourgeois

(a) Residence No. \_\_\_\_\_ St. \_\_\_\_\_ Ward. \_\_\_\_\_  
(Usual place of abode)

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

**PERSONAL AND STATISTICAL PARTICULARS**

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

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OR (OR) WIFE OF \_\_\_\_\_

6. DATE OF BIRTH (MONTH, DAY AND YEAR) July 21, 1849

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.  
78 8 19

**8. OCCUPATION OF DECEASED**

(a) Trade, profession, or particular kind of work Retired  
(b) General nature of industry, business, or establishment in which employed (or employer) Teacher  
(c) Name of employer \_\_\_\_\_

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

10. NAME OF FATHER John Maurice Bourgeois

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

12. MAIDEN NAME OF MOTHER Mrs. Joseph Bonnell

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

14. INFORMANT (Address) Sister M. Semiglia Nazareth Circuit

15. FILED Nov. 10 1927 L. C. Obrock REGISTRAR  
4/10

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) Nov. 10 1927

17. I HEREBY CERTIFY, That I attended deceased from Oct. 31, 1927, to Nov. 10, 1927, that I last saw her alive on Nov. 9, 1927, and that death occurred, on the date stated above, at 4 P

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

Several Paralysis of the insere  
33  
32 A (duration) but longer mos. ds.

CONTRIBUTORY (SECONDARY) \_\_\_\_\_ (duration) \_\_\_\_\_ yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED \_\_\_\_\_

IF NOT AT PLACE OF DEATH? \_\_\_\_\_

DID AN OPERATION PRECEDE DEATH? \_\_\_\_\_ DATE OF \_\_\_\_\_

WAS THERE AN AUTOPSY? \_\_\_\_\_

WHAT TEST CONFIRMED DIAGNOSIS? \_\_\_\_\_

(Signed) Sister M. Semiglia, M. D.  
, 19 (Address) Nazareth Circuit

\*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 Nazareth DATE OF BURIAL Nov 12 1927

20. UNDERTAKER Choppin street U & C. ADDRESS 7814 No. Bldg

2 5

0 18

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

ALL INFORMATION CALLED  
FOR MUST BE WRITTEN ON  
THIS SUPPLEMENTARY.

**1. PLACE OF DEATH**

County St. Louis Registration District No. 1123 File No. ....  
 Township Orondelot Primary Registration District No. 6248B Registered No. 394  
 City..... (No.....) St..... Ward.....

**2. FULL NAME**

(a) Residence. No. Sister Emily Bourgeois 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. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX F 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) S

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

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

**8. OCCUPATION OF DECEASED**

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

10. NAME OF FATHER

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

12. MAIDEN NAME OF MOTHER

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

14. INFORMANT (Address)

15. FILED FEB 22 1928 L. C. Obrock M.D. REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) Nov 10 19 27

17. I HEREBY CERTIFY That I attended deceased from ..... 19....., 19..... that I last saw him alive on ..... 19....., and that death occurred, on the date stated above at ..... m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

General paralysis of the insane

CONTRIBUTORY (SECONDARY) (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH.....

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

WAS THERE AN AUTOPSY?.....

WHAT TEST CONFIRMED DIAGNOSIS.....

(Signed) Paul Hill, M. D. (Address) , 19 (Address)

\*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

20. UNDERTAKER ADDRESS

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNLESS THEY ARE CALLED AS PRESCRIBED BY LAW

Exact statement of OCCUPATION ESSENTIAL & IMPORTANT

**SUPPLEMENTARY**

S-34656