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

Do not use this space.

39057

1. PLACE OF DEATH

County ..... Registration District No. 791 File No. .....

Township ..... Primary Registration District No. 1503 Registered No. 11537

City St Louis (No. Home of Aged ..... St. ..... Ward)

2. FULL NAME Francois Durivage

(a) Residence. No. 2209 Hebert St., 20 Ward. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 49 yrs. 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)
male	white	Widowed

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) April 30th 1856

7. AGE			
73 YEARS	6 MONTHS	25 DAYS	If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED

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

(b) General nature of industry, business, or establishment in which employed (or employer) none

(c) Name of employer

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

PARENTS

10. NAME OF FATHER Narcisse Durivage

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

12. MAIDEN NAME OF MOTHER Zoe Bongeres

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

14. INFORMANT Sister Jeanne
(Address) 2209 Hebert, Str

15. FILED NOV 26 1929 Max C Starkey REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) November 26th 1929

17. I HEREBY CERTIFY, That I attended deceased from Nov. 11, 1929, to Nov. 25, 1929, that I last saw him alive on Nov. 24, 1929, and that death occurred, on the date stated above, at 8 A.M. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

950 Chronic Myocarditis

950

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

CONTRIBUTORY (SECONDARY) Cardiac Asthma

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

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH?

DID AN OPERATION PRECEDE DEATH? No. DATE OF .....

WAS THERE AN AUTOPSY? No.

WHAT TEST CONFIRMED DIAGNOSIS? Clinical Examination

(Signed) Anthony A. Piekarski, M.D.

11/26, 1929 (Address) 1525 a Cass Ave

*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	11-26 1929
20. UNDERTAKER	**ADDRESS**
Arthur J Donnelly	2039 Wash St

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.

WHITE PAPER, WITH UNFADING INK—THIS IS A PERMANENT RECORD

Dr Packenmer
1525 Cass