

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

42936
Do not use this space.

JAN 17 1941

1. PLACE OF DEATH
 (a) County JEFFERSON Registration District No. 421
 (b) Township _____ Primary Registration District No. 5515A Registered No. 116
 (c) City CRYSTAL CITY (d) Street No. _____ St. _____
 (If death occurred in Hospital or Institution, write its name instead of street and number)
 (e) Length of residence in city or town where death occurred 4 yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME AURELIA DeRousse
 (a) Residence, No. CRYSTAL CITY, Mo. St.
 (Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX FEMALE 4. COLOR OR RACE WHITE 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) MARRIED

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) NOVEMBER 6, 1913

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
	<u>27</u>	<u>1</u>	<u>19</u>	

OCCUPATION
 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Housework
 9. Industry or business in which work was done, as saw mill, bank, etc. Own Home
 10. Date deceased last worked at this occupation (month and year) Dec. 1940 11. Total time (years) spent in this occupation _____

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) December 25, 1940

22. I HEREBY CERTIFY, That I attended deceased from 12-22, 1940, to 12-25, 1940
 I last saw h. w. alive on 12-22, 1940 Death is said to have occurred on the date stated above, at 12:48 P.M.
 The principal cause of death and related causes of importance were as follows:
Tuberculosis of the Lungs
 Date of onset 1938

Other contributory causes of importance: 73

Name of operation _____ Date of _____
 What test confirmed diagnosis? _____ Was there an autopsy? _____

23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide? _____ Date of injury _____, 19____
 Where did injury occur? _____ (Specify city or town, county, and State)
 Specify whether injury occurred in industry, in home, or in public place. _____

Manner of injury _____
 Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? No.
 If so, specify _____ (Signed) W. E. Fallick, M. D.
 _____ (Address) De Soto Mo.

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) FLETCHER, MISSOURI

FATHER
 13. NAME ALEXANDER THEBAUG
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) UNKNOWN 9

MOTHER
 15. MAIDEN NAME ELIZABETH HAYES
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) UNKNOWN UNKNOWN

17. INFORMANT LAWRENCE DEROUSSE
 (ADDRESS) FESTUS, Mo.

18. BURIAL, CREMATION, OR REMOVAL
 PLACE DE SOTO, Mo. DATE DEC 28, 1940

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Gen. R. Polittle
Crystal City, Mo.

20. FILED DEC 27, 1940 J. E. Rutledge
 Local Registrar

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

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.

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.....

Licensed Embalmer No.....

P. O. Address.....

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.