

FILED JUL 15 1947

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 22920

Registration District No. 317

Primary Registration District No. 6076

Registrar's No. 1392

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(a) County St. Louis
(b) City or town BALLWIN Mo.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Pine Crest Homes For the Aged
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 5
In this community 5 years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Illinois (b) County Jackson
(c) City or town Murphysboro
(If outside city or town limits, write "RURAL")
(d) Street No. 0
(If rural, give location)
(e) Citizen of foreign country? 2 (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME MARCUS M^cCORD BOUCHEES

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex male 5. Color or race W 6. (a) Single, widowed, married, divorced W 2

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years (Day) (Year)

7. Birth date of deceased July 21 1862
(Month) (Day) (Year)

8. AGE: 84 Years Months 11 Days 8 If less than one day hr. min.

9. Birthplace Murphysboro Ill.
(City, town, or county) (State or foreign country)

10. Usual occupation Retired Railroad Man

11. Industry or business Retired R.R.

12. Name Henry Bouchees

13. Birthplace Jackson Co Ill.
(City, town, or county) (State or foreign country)

14. Maiden name Martha McCord

15. Birthplace Jackson City Ill.
(City, town, or county) (State or foreign country)

16. (a) Informant Karl M. Bouchees
(b) Address Bellville

17. (a) Removal (b) Date thereof 6-29-47
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Bellville
(d) Signature of funeral director Rite Gardner
(e) Address Bellville Ill.

19. (a) 6-30-47 (b) Carla J. May
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 29 year 1947 hour 10 minute P. M.

21. I hereby certify that I attended the deceased from June 13 1947 to June 29 1947

that I last saw him alive on June 27 1947 and that death occurred on the date and hour stated above.

Immediate cause of death chronic myocardial ischemia Duration _____

Due to primary arteriosclerosis

Due to 93D

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations _____ Of autopsy _____

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

(c) Where did injury occur? _____ (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature G. J. Overton MD (M. D. or other) _____ Address 3107 Poplar Date signed 6-29-47

JUL 24 1947

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.

Mot. Embalmer

Signed..... *P*

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, fact should be so stated above.