

FILED AUG 18 1948

STANDARD CERTIFICATE OF DEATH

State File No. _____

Registration District No. 366Primary Registration District No. 6244Registrar's No. 43

1. PLACE OF DEATH:

(a) County Washington
 (b) City or town Cadet R.R. 1 (Union)
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: 9
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution _____ (Specify whether)
 In this community Life
 years, months or days

3. (a) PRINT FULL NAME Joseph A. Bourisaw

3. (b) If veteran, name war No 3. (c) Social Security No. None

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Single
 6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
 7. Birth date of deceased June 23 1907
 (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
41 1 16 hr. 7 min.

9. Birthplace Old Mines Mo.
 (City, town, or county) (State or foreign country)

10. Usual occupation Merchant

11. Industry or business _____

MOTHER FATHER { 12. Name Roussan Bourisaw
 { 13. Birthplace Old Mines Mo.
 (City, town, or county) (State or foreign country)
 { 14. Maiden name Lanora Roussan
 { 15. Birthplace Richwoods Mo.
 (City, town, or county) (State or foreign country)

16. (a) Informant Leo Bourisaw
 (b) Address Cadet Mo. R.R. 1
 17. (a) Burial (b) Date thereof 8-12-48
 (Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation Old Mines Mo.
 18. (a) Signature of funeral director Boyer Funeral Home
 (b) Address Potosi Mo.
 19. (a) 8/10/48 (b) Helmuth Endall
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Washington
 (c) City or town Old Mines
 (If outside city or town limits, write "RURAL")
 (d) Street No. Cadet Mo. R.R. 1,
 (If rural, give location)
 (e) Citizen of foreign country? no (Yes or No)
 If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug. day 9
 year 1948 hour 2 minute 0 P.M.

21. I hereby certify that I attended the deceased from 5-30 1948 to 8-9 1948
 that I last saw him alive on 8-8 1948
 and that death occurred on the date and hour stated above.
 Immediate cause of death Carcinomatous Duration _____

Due to _____
 Due to _____
 Other conditions none
 (Include pregnancy within 3 months of death)
 Major findings: Of operations 556
 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: SUPPLEMENTARY INFORMATION REQUESTED
 (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?
 _____ (Specify type of place)
 While at work? (c) Means of injury _____

23. Signature Ed J. Wellard (M. D. or other) MD
 Address Potosi, Mo Date signed 8-10-48

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

RECEIVED

Director, Health Officer No. 4
District File Number 848-1043
Date Filed 8-17-48

NOV 20 1948

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 K
....., Registered Apprentice No.
working under my personal supervision.

Signed Mary M. Smith
Licensed Embalmer No. 4394
P. O. Address Potosi, Mo

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.

Registration District No. 66 Primary Registration District No. 6247

1. PLACE OF DEATH:

(a) County Washington
(b) City or town Rural
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community _____ years, months or days

3. (a) PRINT FULL NAME Joseph A Bourisau

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

4. Sex M 5. Color or race W

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

7. Birth date of deceased June 20 1920
(Month) (Day) (Year)

8. AGE: Years 41 Months _____ Days _____ (If less than one day hr. _____ min. _____)

9. Birthplace _____ (City, town, or county) (State or foreign country) MO

MOTHER FATHER { 12. Name _____
13. Birthplace _____ (City, town, or county) (State or foreign country)
14. Maiden name _____
15. Birthplace _____ (City, town, or county) (State or foreign country)

16. (a) Informant _____ (b) Address _____

17. (a) _____ (b) Date thereof _____ (Month) (Day) (Year)
(Burial, cremation, or removal)
(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____ (b) Address _____

19. (a) _____ (b) _____
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month _____ year 19 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ to _____, 19____; that I last saw him _____ alive on _____, 19____; and that death occurred on the date and hour stated above. Immediate cause of death _____

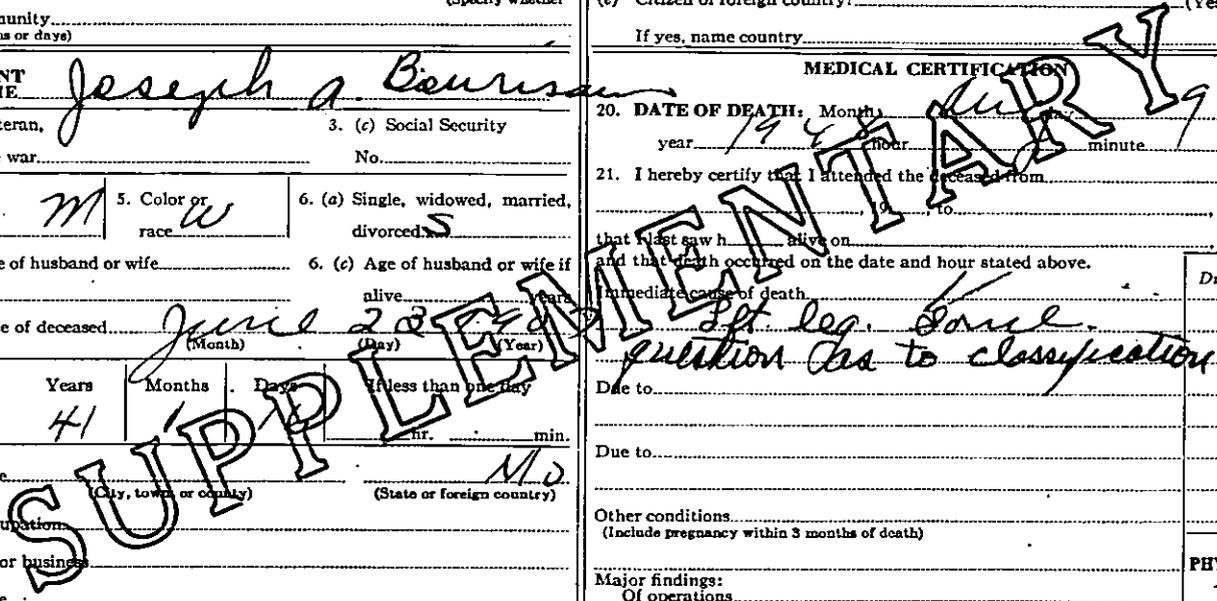
Due to _____
Due to _____
Other conditions _____ (Include pregnancy within 3 months of death)

Major findings: Of operations _____
Of autopsy _____ 556

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 _____ (M. D. or other) _____
Address _____ Date signed _____



PHYSICIAN

Underline the cause to which death should be charged statistically.

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

28698

of the
P. H. H. P.