

FILED DEC 27 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

42299
State File No.

318
REG. DIST. NO.

1003
PRIMARY REG. DIST. NO.

10861
Registrar's No.

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

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Mo.	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN ST. LOUIS		c. LENGTH OF STAY (in this place)	
d. FULL NAME OF HOSPITAL OR INSTITUTION MOR BAPTIST Hospital		d. STREET ADDRESS (If rural, give location) 23 - 1809 OHIO AV.	
3. NAME OF DECEASED (Type or Print) CLARA Bouquet		4. DATE OF DEATH (Month) (Day) (Year) DEC 17-49	
5. SEX FE. /	6. COLOR OR RACE W.	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) M.	8. DATE OF BIRTH APRIL 21-1869
9. AGE (In years last birthday) 80 YRS	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEKEEPER	10b. KIND OF BUSINESS OR INDUSTRY OWN	11. BIRTHPLACE (State or foreign country) POND MO
12. CITIZEN OF WHAT COUNTRY? U.S.A.	13a. FATHER'S NAME John KISSELS	13b. MOTHER'S MAIDEN NAME KAROLINA UNKNOWN	14. NAME OF HUSBAND OR WIFE FRED BOUQUET
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME ADDRESS Mr Fred Bouquet 1809 Ohio av.	
MEDICAL CERTIFICATION			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.		I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Uremia</u>	
		ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Bowel obstruction</u>	
		DUE TO (c) <u>Ruptured diverticuli of colon - healed, Post operative adhesions.</u>	
		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	
19a. DATE OF OPERATION 12-15-49		19b. MAJOR FINDINGS OF OPERATION <u>see above</u>	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) 122. MO.			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR 577X			
22. I hereby certify that I attended the deceased from <u>6-11, 1948</u> , to <u>12-16, 1949</u> , that I last saw the deceased alive on <u>12-16, 1949</u> , and that death occurred at <u>3 P. m.</u> , from the causes and on the date stated above.			
23a. SIGNATURE (Degree or title) Elwin P. Deatt, M.D.		23b. ADDRESS 3258 Lafayette	
23c. DATE SIGNED 12-17-49			
24a. BURIAL CRYPTS, TOMB, REMOVAL (Specify) BURIAL		24b. DATE DEC 19-49	
24c. NAME OF CEMETERY OR CREMATORY SUN SET Burial PK		24d. LOCATION (City, town, or county) (State) St. Louis MO.	
DATE REC'D BY LOCAL REG. DEC 17 1949		REGISTRAR'S SIGNATURE [Signature]	
25. FUNERAL DIRECTOR'S SIGNATURE E. J. Schurr		ADDRESS 3125 Lafayette av	

nil

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.....

.....
working under my personal supervision.

Student Embalmer No.....

Signed.....

John Ballmer

Signed.....

Student Embalmer

Licensed Embalmer No. *4014*

P. O. Address *3125 Lafayette St*

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.