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

Do not use this space.

16476

1. PLACE OF DEATH

County ..... Registration District No. 791

Township ..... Primary Registration District No. 1003

City St Louis (No. City Hospital St. ..... Ward)

File No. .....

Registered No. 4574

2. FULL NAME Charles Boucher

(a) Residence. No. 1462 Warren St., 26 Ward.
(Usual place of abode)

(If nonresident, give city or town and State)

Length of residence in city or town where death occurred 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	Married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Feb 22 1872

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
	57	1	27	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Machinist
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

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

PARENTS

10. NAME OF FATHER Wm Boucher

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

12. MAIDEN NAME OF MOTHER Kate Don't know

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

14. INFORMANT ~~Jos Kelly Information~~ E. R. Lane
(Address) City Hospital

15. FILED APR 19 1929 Max C. Starkloff
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) April 18 1929

17. I HEREBY CERTIFY, That I attended deceased from April 18 1929, to April 18 1929 that I last saw him alive on April 18 1929 and that death occurred, on the date stated above, at 7 45 P.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Alcoholic cirrhosis of liver

1244 (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) .....
(duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED .....
IF NOT AT PLACE OF DEATH .....

8 DID AN OPERATION PRECEDE DEATH? ..... DATE OF .....

WAS THERE AN AUTOPSY? .....

WHAT TEST CONFIRMED DIAGNOSIS? .....

4/19, 1929 (Signed) Edmund R. Shorida, M.D.
(Address) City Hospital

*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 Memorial Park — DATE OF BURIAL April 22 1929

20. UNDERTAKER Hy Leudner Und — ADDRESS 1417 N. Market 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.

WRITE PLAINLY, WITH PEN OR BLACK INK—THIS IS A PERMANENT RECORD

Doercher