

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

Do not use this space.

**35851**

**1. PLACE OF DEATH**

County Barnard Hosp.

Registration District No. 791

Township \_\_\_\_\_

Primary Registration District No. 1003

City St. Louis, Mo (No. \_\_\_\_\_) St. \_\_\_\_\_ Ward \_\_\_\_\_

File No. \_\_\_\_\_

Registered No. 10366

**2. FULL NAME**

Albert (Bouphers) Bouphers

(a) Residence. No. 4605<sup>a</sup> Page St. 11 Ward \_\_\_\_\_ (If nonresident, give city or town and State)

Length of residence in city or town where death occurred 2 yrs. 4 mos. 2 ds. How long in U. S., if of foreign birth? \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX Male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) single

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 12-8-1904

7. AGE YEARS MONTHS DAYS If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.  
26 9 29

**8. OCCUPATION OF DECEASED**

(a) Trade, profession, or particular kind of work. Laborer  
(b) General nature of industry, business, or establishment in which employed (or employer) \_\_\_\_\_  
(c) Name of employer \_\_\_\_\_

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

**PARENTS**  
10. NAME OF FATHER Joseph Bouphers  
11. BIRTHPLACE OF FATHER (CITY OR TOWN) See.  
(STATE OR COUNTRY)  
12. MAIDEN NAME OF MOTHER Florence Allen  
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) See.  
(STATE OR COUNTRY)

14. INFORMANT Florence Bouphers  
(Address) 4605<sup>a</sup> Page

15. FILED 10/11/31 Max E. Farley REGISTRAR

**2 MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) 10/7 19 31

17. I HEREBY CERTIFY, That I attended deceased from 7/15/31, 1931, to 10/7/31, 1931, that I last saw him alive on 10/7/31, 1931, and that death occurred, on the date stated above, at 6:10 A. m.

**THE CAUSE OF DEATH\* WAS AS FOLLOWS:**

Carcinomatosis,  
primary in ampulla of  
Water.

41.1 (duration) \_\_\_\_\_ yrs. 3? mos. \_\_\_\_\_ ds.  
CONTRIBUTORY (SECONDARY) 4/6/31 (duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

**18. WHERE WAS DISEASE CONTRACTED**

IF NOT AT PLACE OF DEATH \_\_\_\_\_

DID AN OPERATION PRECEDE DEATH? yes DATE OF 7/22/31  
WAS THERE AN AUTOPSY? yes DATE OF 9/23/31  
WHAT TEST CONFIRMED DIAGNOSIS clinical + microscopic  
(Signed) F. W. Hedgecock, M. D.  
. 19 \_\_\_\_\_ (Address) 3427 Washington ave

\*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 Kennedy Ill. DATE OF BURIAL 10/12/31

20. UNDERTAKER J. H. Nelson ADDRESS Kennedy Ill.

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.

12. 8 1904

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