

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 2774  
Registrar's No. 14-11

Registration District No. 475

Primary Registration District No. 5580

1. PLACE OF DEATH:

(a) County JEFFERSON FILED FEB 13 1940  
(b) City or town RURAL - MERAMEC TWP.  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: ST. JOSEPH'S HILL INFIRMARY  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 13 DAYS  
(Specify whether years, months or days)

3. (a) PRINT FULL NAME FRANK BOURBON 6/15  
3. (b) If veteran, name war   
3. (c) Social Security No.

4. Sex MALE 5. Color or race WHITE  
6. (a) Single, widowed, married, divorced MARRIED  
6. (b) Name of husband or wife ANNA MILLIRON BOURBON  
6. (c) Age of husband or wife if alive 44 years  
7. Birth date of deceased 8 25 1893  
(Month) (Day) (Year)

8. AGE: Years 46 Months 4 Days 29  
If less than one day hr. min.

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

10. Usual occupation FARMER

11. Industry or business

12. Name TIMON BOURBON

13. Birthplace MISSOURI  
(City, town, or county) (State or foreign country)

14. Maiden name EMMA FROST  
15. Birthplace MISSOURI  
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature ST. JOSEPH'S HILL INFIRMARY

(b) Address Brother Bonaventur, O. S. F.

17. (a) Funeral (Burial, cremation, or removal) (b) Date thereof 1-26-40  
(Month) (Day) (Year)

(c) Place: burial or cremation Catholic Mausoleum, ST. CLAIR, MO.

18. (a) Signature of funeral director Overland, Mo. 351

(b) Address 24 Jan 1940

19. (a) 24 Jan 1940 (Date received local registrar) (b) Janina A. Townsend (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County 0  
(c) City or town FLORISSANT  
(If outside city or town limits, write "RURAL")  
(d) Street No. ROUTE 2  
(If rural, give location)  
(e) If foreign born, how long in U. S. A.? \_\_\_\_\_ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 23  
year 1940 hour 3 minute 10 P. M.

21. I hereby certify that I attended the deceased from Jan 13, 1940 to Jan 13, 1940  
that I last saw him alive on Jan 13, 1940  
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Vascular Sclerosis  
Due to \_\_\_\_\_  
Due to \_\_\_\_\_

Other conditions 12 1/2 hrs  
(Include pregnancy within 3 months of death)

Major findings:  
Of operations \_\_\_\_\_  
Of autopsy no

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) Means of injury 1  
Signature Jesse S. Sargent (M. D. or other) 1  
Address Boonville, Mo. Date signed 1-23-40

Duration \_\_\_\_\_  
PHYSICIAN \_\_\_\_\_  
Underline the cause to which death should be charged statistically

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE 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.

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**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.

Signed.....

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, above space should be left blank.**