

FILED OCT 2 - 1943

Registration District No. 318

Primary Registration District No. 1003

Registrar's No. 8433

1. PLACE OF DEATH:

(a) County St. Louis
(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
3244 Watson Rd.
(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 Cecelia Bouligny

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

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced, Widowed

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

7. Birth date of deceased Oct. 11th 1879
(Month) (Day) (Year)

8. AGE: Years 63 Months 11 Days 10 If less than one day _____ hr. _____ min.

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

10. Usual occupation Housewife

11. Industry or business

12. Name Joseph Wisniewski 13. Birthplace Poland
(City, town, or county) (State or foreign country)

14. Maiden name Katherine Perwich 15. Birthplace Germany
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Ethel Cottrill (b) Address 3244 Watson Rd.

17. (a) Burial (b) Date thereof 9-24-43
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Calvary Cemetery

18. (a) Signature of funeral director Kriegshauser Mortuary
(b) Address 4228 So. Kingshighway Blvd.

19. (a) SEP 23 1943 (b) J. J. [Signature]
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County _____
(c) City or town St. Louis
(If outside city or town limits, write "RURAL")
(d) Street No. 3244 Watson Rd.
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept. day 21st
year 1943 hour 11:20 minute A.M.

21. I hereby certify that I attended the deceased from March, 1941, to 9-21, 1943.
that I last saw her alive on 9-20, 1943
and that death occurred on the date and hour stated above.

Immediate cause of death _____
Carcinoma of sigmoid colon with metastasis
Due to _____
Due to _____

Other conditions (Include pregnancy within 3 months of death)

Major findings: Carcinoma of sigmoid
Of operations: extensive for removal 4-16-41
Of autopsy _____

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?

23. Signature Earl R. Rice (M. D. or other) _____
Address 644 Olive St. Date signed 9-22-43

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

MOTHER FATHER

PHYSICIAN

Underline the cause to which death should be charged statistically.

611 Olive St.
Ch. 5844 - Pa. 2357
13³⁰ to 3

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 Edwin N. Speckmann

Licensed Embalmer No. 3024

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, fact should be so stated above.