

FILED MAY 9 1944
318

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

12565

State File No.

Registration District No.

Primary Registration District No.

1003

Registrar's No.

3873

1. PLACE OF DEATH:

(a) County _____
(b) City or town St. Louis Mo.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
St. Anthony Hospital 8 Days
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 8 Days
(Specify whether
In this community _____
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County _____
(c) City or town St. Louis
(If outside city or town limits, write "RURAL")
(d) Street No. 2703 Virginia Ave
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Baby Mary Bouchaert

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

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

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

7. Birth date of deceased April 17/1944
(Month) (Day) (Year)

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

9. Birthplace St. Louis Mo.
(City, town, or county) (State or foreign country)

10. Usual occupation Nil

11. Industry or business _____

MOTHER FATHER {
12. Name Leo Bouchaert
13. Birthplace St. Louis
(City, town, or county) (State or foreign country)
14. Maiden name Corine Knight
15. Birthplace St. Louis
(City, town, or county) (State or foreign country)

16. (a) Informant Leo Bouchaert
(b) Address 2703 Virginia Ave.

17. (a) Burial (b) Date thereof April 26/44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation S.S. Peter & Paul

18. (a) Signature of funeral director Thorndike & Co.
(b) Address 2906 Gravois Ave.

19. (a) APR 26 1944 (b) J. J. Bouchaert
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 25 year 1944 hour 4 minute 30 P. M.

21. I hereby certify that I attended the deceased from admitted
4-17- 1944, to 4-25- 1944

that I last saw her alive on 4-25- 1944; and that death occurred on the date and hour stated above.

Immediate cause of death congenital absence of interventricular septum of heart Duration _____

Due to _____
Due to _____

Other conditions None - lips complete
(Include pregnancy within 8 months of death)

Major findings: absence of hard & soft palate PHYSICIAN _____
Of operations _____

Of autopsy see above
Underline the cause to which death should be charged statistically.

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) (e) Means of injury _____

23. Signature W. J. Allen (M. D. or other) _____
Address 3625 D. Grand Date signed 4/26/44

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

Not embalmed
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 *David Van Jones*

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, fact should be so stated above.