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FILED DEC 18 1944

Registration District No. 227 Primary Registration District No. 2395804 Registrar's No. 57

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

1. PLACE OF DEATH:

(a) County Monroe
 (b) City or town Paris, R.R. Jackson
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: County Infirmary
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 5
(Specify whether years, months or days)

In this community 5
years, months or days

3. (a) PRINT FULL NAME W. B. Bouscalle
 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, widowed
 6. (b) Name of husband or wife George Bouscalle
 6. (c) Age of husband or wife if alive deceased
 7. Birth date of deceased: 1.10.1887
(Month) (Day) (Year)

8. AGE: Years 57 Months 03 Days 09
 If less than one day hr. 9 min.

9. Birthplace: Paris, Louisiana
(City, town, or county) (State or foreign country)

10. Usual occupation Farming

11. Industry of business Farming
 12. Name George Bouscalle
 13. Birthplace Paris, Louisiana
(City, town, or county) (State or foreign country)
 14. Maiden name 9
 15. Birthplace 9
(City, town, or county) (State or foreign country)

16. (a) Informant L. E. Haughton
 (b) Address Paris, La
 17. (a) burial (b) Date thereof 10-7-44
(Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation Funeral Home, Crowley

18. (a) Signature of funeral director W. A. Thompson
 (b) Address Madison, Mo
 19. (a) 10-7-44 (b) W. A. Thompson
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County County 69
 (c) City or town Florida, R.R.
(If outside city or town limits, write "RURAL")
 (d) Street No. /
(If rural, give location)
 (e) Citizen of foreign country? / (Yes or No)
 If yes, name country U

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 4
 year 1944 hour 2 minute 45 M.
 21. I hereby certify that I attended the deceased from Oct 1
 1944 to Oct 4 1944
 that I last saw him alive on Oct 1 1944
 and that death occurred on the date and hour stated above.

Immediate cause of death: Cerebral thrombosis
 Duration 4 days
 Due to arteriosclerosis NIK
 Due to /

Other conditions: 83a
(Include pregnancy within 3 months of death)
 Major findings: 83a
 Of operations /
 Of autopsy /

PHYSICIAN
 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)
 Means of injury /
 23. Signature W. A. Thompson (M. D. or other)
 Address Paris, Mo Date signed 10-7-44

RECEIVED

District Health Officer No. 10

District No. 12-44-2046

Date Filed DEC 14 1944

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 Mrs. A. A. Thompson
Licensed Embalmer No. 2282
P. O. Address Madison, Wis.

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.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No.

JAN 1944

Registrar's No.

57

Registration District No. 227

Primary Registration District No. 5804

1. PLACE OF DEATH:

(a) County Monroe
(b) City or town Rural Jackson Miss
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:

(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 W. B. Bonsall

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

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

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

7. Birth date of deceased May 10
(Month) (Day) (Year)

8. AGE: Years 84 Months _____ Days _____ If less than one day, _____ min.

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

10. Usual occupation Farming

11. Industry or business _____
MOTHER FATHER { 12. Name _____
13. Birthplace _____ (City, town, or county) (State or foreign country)
14. Maiden name AK _____
15. Birthplace _____ (City, town, or county) (State or foreign country)

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) 10-6-44 (b) Maynard
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____

(c) City or town _____ (If outside city or town limits, write "RURAL")

(d) Street No. _____ (If rural, give location)

(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 10 Year 1944 Hour _____ Minute _____ M.

21. I hereby certify that I attended the deceased from _____ 19____
that I last saw him _____ alive on _____ 19____
and that death occurred on the date and hour stated above.
Immediate cause of death _____

Duration

Due to _____

Due to _____

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings: _____
Of operations _____

Of autopsy _____

PHYSICIAN

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 _____ (M. D. or other) _____

Address _____ Date signed _____

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

SUPPLEMENTARY

S-41660 1944