

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED MAY 10 1945

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____

Registration District No. 319

Primary Registration District No. 6079

Registrar's No. 22

1. PLACE OF DEATH:

(a) County Ste. Genevieve
(b) City or town RURAL
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: St. Genevieve Hosp
(If not in hospital or institution, write street number or location) 1
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community LIFE years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Ste. Genevieve
(c) City or town RURAL 95
(If outside city or town limits, write "RURAL") 0
(d) Street No. _____ (If rural, give location) 0
(e) Citizen of foreign country? NO (Yes or No) 0
If yes, name country _____

3. (a) PRINT FULL NAME Gertrude Figue

3. (b) If veteran, name war _____ 3. (c) Social Security No. 498-05-454

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Peter A. Figue 6. (c) Age of husband or wife if alive 39 years
7. Birth date of deceased August 13 1918
(Month) (Day) (Year)

8. AGE: Years 26 Months 7 Days 28 If less than one day hr. _____ min. _____

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

10. Usual occupation At Home

11. Industry or business _____

MOTHER } 12. Name John Biesen
13. Birthplace Ste. Genevieve Co. Mo.
(City, town, or county) (State or foreign country)
14. Maiden name Catherine Biesen
15. Birthplace Ste. Genevieve Co. Mo.
(City, town, or county) (State or foreign country)

16. (a) Informant Peter A. Figue

(b) Address Ste. Genevieve Mo.

17. (a) Burial (b) Date thereof 4-3-45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Ozora Mo.

18. (a) Signature of funeral director Geo. C. Barber

(b) Address Ste. Genevieve Mo.

19. (a) Apr 3 - 45 (b) T.W. Douglas
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 31
year 1945 hour 6 minute 40 P.M.

21. I hereby certify that I attended the deceased from _____, 1942 to March 31, 1945;
that I last saw her alive on Mar 16, 1945;
and that death occurred on the date and hour stated above.

Immediate cause of death Acute coronary dilatation Duration _____

Due to Pulmonary Tuberculosis Bilateral Syndrome

Due to _____

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

Major findings: Of operations 13K

Of autopsy _____

22. If death was due to external causes, fill in the following:

(c) 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 [Signature] (M. D. or other) MD

Address Ste. Genevieve Mo. Date signed 4-2-45

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

706

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED

District Health Officer No. 4

District File Number 545-607

Date Filed 5-9-45

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 Leo C. Baker

Licensed Embalmer No. 1985

P. O. Address St. Lawrence Mo

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.