V. S. No. 2
00M—5-43
Rev. 5-17-39
1 X36671

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED JUN 9 1945

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 14955

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 4741

1. PLACE OF DEATH:
(a) County
(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 6220 Alamo Avenue
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution (Specify whether years, months or days)
In this community

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County 009 75
(c) City or town St. Louis
(If outside city or town limits, write "RURAL")
(d) Street No. 6220 Alamo Avenue
(If rural, give location)
(e) Citizen of foreign country? 0 (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Marie Isabelle Boulicault
3. (b) If veteran, name war No.
3. (c) Social Security No. None
4. Sex Female 1
5. Color or race White
6. (a) Single, widowed, married, divorced Widow 2
6. (b) Name of husband or wife Leon C. Boulicault, Dec'd 11/21/21
6. (c) Age of husband or wife if alive years
7. Birth date of deceased December 12, 1867 (Month) (Day) (Year)

8. AGE: Years 77 Months 5 Days 15 If less than one day hr. min.

9. Birthplace St. Louis, Mo. (City, town, or county) 0 (State or foreign country)
10. Usual occupation At home
11. Industry or business Housewife

MOTHER FATHER
12. Name Jean B. Bruno,
13. Birthplace France (City, town, or county) 5 (State or foreign country)
14. Maiden name Victorine Varriere
15. Birthplace France (City, town, or county) 5 (State or foreign country)

16. (a) Informant Victorine Boulicault
(b) Address 6220 Alamo Ave.
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/29/45 (Month) (Day) (Year)
(c) Place: burial or cremation Valhalla
18. (a) Signature of funeral director Robert J. Ambruster
(b) Address Clayton Rd. at Concordia Lane
19. (a) MAY 29 1945 (Date received local registrar) J. F. Bueck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 27 year 1945 hour 3 minute 15 P.M.
21. I hereby certify that I attended the deceased from November 1944, to May 27, 1945 that I last saw her alive on May 27, 1945; and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Hemorrhage — Duration
Due to Right Hemiplegia
Due to Diabetes Mellitus
Other conditions (Include pregnancy within 3 months of death)
Major findings:
Of operations
Of autopsy No 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? (Specify type of place)
While at work? (e) Means of injury

23. Signature [illegible] (M. D. or [illegible])
Address Carlton Bldg. Date signed 5/28/45

877 (Licensed Embalmer's Statement on Reverse Side)

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. 1994

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.