DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 42230

FILED JAN 9 1946

Registration District No. 296 Primary Registration District No. 4445 Registrar's No. 37

1. PLACE OF DEATH:

(a) County: Ray

(b) City or town: Orrick (If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: None (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: 15 Years

2. USUAL RESIDENCE OF DEACEASED:

(a) State: Mo. (b) County: Ray

(c) City or town: Orrick, Mo. (If outside city or town limits, write "RURAL")

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

(e) If foreign born, how long in U. S. A.? ____ years.

3. (a) PRINT FULL NAME: Josephine A. Chouquette

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: Sept. (Month) 12, (Day) 1858 (Year)

8. AGE: Years 87 Months 3 Days 13 If less than one day ____ hr. ____ min.

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

10. Usual occupation: Housekeeper

11. Industry or business: ____

FATHER 12. Name: Henry Chouquette

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

MOTHER 14. Maiden name: Virginia LeMay

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

16. (a) Informant's own signature: Virginia E. Dorton

(b) Address: Orrick, Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-27-45 (Month) (Day) (Year)

(c) Place: burial or cremation: South Point Cem.

18. (a) Signature of funeral director: B. N. Good

(b) Address: Orrick, Mo.

19. (a) 12/28/45 (Date received local registrar) (b) Helen J. Larkin (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 23 year 1945 hour 9 minute 45 AM.

21. I hereby certify that I attended the deceased from ____, 19__, to ____, 19__; that I last saw h____ alive on ____, 19__; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Cerebral haemorrhage	
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? ____ (Specify type of place)

While at work? ____ (e) Means of injury ____

23. Signature: J. F. Baber, Ray Co. Coroner (M. D. or other)

Address: Richmond Mo. Date signed 12-27-45

(Licensed Embalmer's Statement on Reverse Side)

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

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

Rev. 5-17-39 1 X19511

RECEIVED
District Health Officer No. 8,
Local File Number
Date Filed 1-8-46

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 J E Broadhurst

Licensed Embalmer No. 2171

P. O. Address Rayville

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, above space should be left blank.