

S. No. 2
DM-5-43
5-17-39
I X36671

State File No. _____

FILED FEB 16 1948

Registration District No. 299

Primary Registration District No. 6079

Registrar's No. 5

1. PLACE OF DEATH:

(a) County STE. GENEVIEVE
(b) City or town RURAL STE. GENEVIEVE T.S.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 1
(If not in hospital or institution, write street number or location)
(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
(If outside city or town limits, write "RURAL")
(d) Street No. Ste Genevieve TWP
(If rural, give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME JOHANNA BEQUETTE

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 WIDOWED

6. (b) Name of husband or wife FELIX I BEQUETTE, Sr 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased MAR 21 1864
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>83</u>	<u>10</u>	<u>1</u>	hr. _____ min. _____

9. Birthplace STE GENEVIEVE MO (City, town, or county) (State or foreign country)

10. Usual occupation AT HOME

11. Industry or business _____

MOTHER FATHER

12. Name Johannes J. Dohl

13. Birthplace GERMANY (City, town, or county) (State or foreign country)

14. Maiden name CATHERINE NAU

15. Birthplace GERMANY (City, town, or county) (State or foreign country)

16. (a) Informant Felix Bequette, Jr

(b) Address Ste. Genevieve Mo

17. (a) BURIAL (b) Date thereof 1-24-48
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Ste. Genevieve Mo

18. (a) Signature of funeral director Doc. Bisher

(b) Address Ste. Genevieve Mo

19. (a) 1-26-48 (b) Theresa M. Karl
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month JAN day 22 year 1948 hour _____ minute 7 A.M.

21. I hereby certify that I attended the deceased from Jan 5 1948 to Jan 22 1948
that I last saw her alive on Jan 21 1948
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Hemorrhage
Due to Arteriosclerosis

Duration 1/5/48

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

Major findings:
Of operations _____
Of autopsy GBA

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? 0

(Specify type of place)
While at work? _____ (e) Means of injury _____

23. Signature Pl. Lanning M.D. (M. D. or other) _____
Address Ste. Genevieve Mo Date signed 1-22/48

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

1th Officer No. 4
File Number 248-144
Date Filed 2-11-48

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..... *Lee C. Barber*

Licensed Embalmer No. *1985*

P. O. Address *100 Summer St*

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.