

No. 300
M-10-47
7-5-17-39
I 3908

FEDERAL SECURITY AGENCY

National Office of Vital Statistics

FILED DEC 29 1948

Registration District No. 149

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

40059

State File No.

Primary Registration District No. 1002

Registrar's No.

5136

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

1. PLACE OF DEATH:

(a) County Jackson
(b) City or town Kansas City
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
General Hospital No. 1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 6 days
(Specify whether
In this community 20 years
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson
(c) City or town Kansas City
(If outside city or town limits, write "RURAL")
(d) Street No. 811 E. Armour
(If rural, give location)
(e) Citizen of foreign country? unknown (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME

Charles J. Chouinard

3. (b) If veteran, name war No

3. (c) Social Security No. 573-09-1037

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Mrs Agnes Chouinard 6. (c) Age of husband or wife if alive 55 yrs years

7. Birth date of deceased. October 16, 1883
(Month) (Day) (Year)

8. AGE: Years 65 Months 2 Days 1 If less than one day hr. min.

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

10. Usual occupation Switchboard Operator

11. Industry or business Ricardo Hotel

MOTHER FATHER

12. Name No record

13. Birthplace No record
(City, town, or county) (State or foreign country)

14. Maiden name No record

15. Birthplace No record
(City, town, or county) (State or foreign country)

16. (a) Informant Jack Chouinard

(b) Address St. Louis, Mo.

17. (a) Burial (b) Date thereof Dec. 20, 1948
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Calvary

18. (a) Signature of funeral director Thomas E. Quirk

(b) Address 4316 Troost Ave.

19. (a) 12-18-48 (b) Heraldine Holmes
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec. day 17
year 1948 hour 5 minute 45 A.M.

21. I hereby certify that I attended the deceased from Dec. 11, 1948, to Dec. 17, 1948, that I last saw him alive on Dec. 17, 1948, and that death occurred on the date and hour stated above.

Immediate cause of death Coronary occlusion

Due to _____

Due to _____

Other conditions 942
(Include pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy None

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

Wm. W. Hart
While at work? (Specify type of place) (e) Means of injury

23. Signature Wm. W. Hart (M. D. or other) MD
Address Med. Dir. Gen'l Hosp. Date signed 12-17-48

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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.....

Thomas E. Quinn
.....
Licensed Embalmer No. *3775*
P. O. Address *A. C. The.*

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.