

FILED OCT 3 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 32629

BIRTH NO. _____		REG. DIST. NO. <u>319</u>		PRIMARY REG. DIST. NO. <u>4469</u>		Registrar's No. <u>59</u>		
1. PLACE OF DEATH a. COUNTY <u>ST. GENEVIEVE</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>MISSOURI</u> b. COUNTY <u>ST. GENEVIEVE MO.</u>				
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>ST. GENEVIEVE</u>		c. LENGTH OF STAY (in this place) <u>LIFE</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>ST. GENEVIEVE</u>		d. STREET ADDRESS (If rural, give location) <u>179 N. 2nd. ST</u>		
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>NONE</u>								
3. NAME OF DECEASED (Type or Print) a. (First) <u>JOSEPH</u> b. (Middle) <u>E.</u> c. (Last) <u>GOURO</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>SEPT 18 1949</u>					
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>MARRIED</u>		8. DATE OF BIRTH <u>MARCH 13 1869</u>		
9. AGE (In years last birthday) <u>80</u>		IF UNDER 1 YEAR Months		IF UNDER 2 HRS. Hours		Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED FARMER</u>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>RIVER AUX VASES MO.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13a. FATHER'S NAME <u>ELI GOURO</u>			13b. MOTHER'S MAIDEN NAME <u>MARCELETE GRIFFARD</u>			14. NAME OF HUSBAND OR WIFE <u>ANNA LAROSE</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT'S SIGNATURE OR NAME <u>Winifred Hovors Ste. Genevieve Mo</u>				
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Arteriosclerosis</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Chronic nephritis</u> DUE TO (c) <u>Chronic myocarditis</u> II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Bronchial pneumonia</u>					INTERVAL BETWEEN ONSET AND DEATH <u>4/16/45</u> <u>?</u> <u>4-2-21</u> <u>9/14/49</u>	
19a. DATE OF OPERATION <u>X</u>		19b. MAJOR FINDINGS OF OPERATION <u>X</u>					20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify) <u>X</u>		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>X</u>		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <u>X</u>				
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (m.) <u>X</u>		21e. INJURY OCCURRED WHILE AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>X</u>				
22. I hereby certify that I attended the deceased from <u>April 16, 1945</u> , to <u>Sept. 18, 1949</u> , that I last saw the deceased alive on <u>Sept. 17, 1949</u> , and that death occurred at <u>5:45A. m.</u> , from the causes and on the date stated above.								
23a. SIGNATURE <u>R. L. Lanning M.D.</u> (Degree or title)				23b. ADDRESS <u>Ste. Genevieve Mo</u>		23c. DATE SIGNED <u>9/18/49</u>		
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24b. DATE <u>SEPT 20 1949</u>		24c. NAME OF CEMETERY OR CREMATORY <u>VALLESPRING</u>		24d. LOCATION (City, town, or county) (State) <u>ST. GENEVIEVE MO</u>		
DATE REC'D BY LOCAL REG. <u>Sept. 20, 1949</u>		REGISTRAR'S SIGNATURE <u>L. D. Kell</u>		350		25. FUNERAL DIRECTOR'S SIGNATURE <u>R. C. Basher - Ste. Genevieve Mo</u> ADDRESS		

(Licensed Embalmer's Statement on Reverse Side)

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

RECEIVED 9-26-49

District Health Officer No. 4

District File Number 949-1247

Date Filed

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

Student Embalmer No.

working under my personal supervision.

Signed *Adrian J. Ehler*

Signed Student Embalmer

Licensed Embalmer No. 4740

P. O. Address *Ste. Genevieve*

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.