

FILED APR 9 1958

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-011553
STATE FILE NUMBER

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **3721**

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-57
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1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURI b. COUNTY			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. LOUIS Mo		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN ST. LOUIS	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 4123 HAVEN		Length of stay in 1b		d. STREET ADDRESS (If outside, give location) 4123 HAVEN	
3. NAME OF DECEASED (Type or print) First JOSEPH Middle Last DUCOTE			4. DATE OF DEATH Month Apr. Day 1 Year 1958		
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> 2 DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Nov. 16 1878	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED PACKER		10b. KIND OF BUSINESS OR INDUSTRY RICE STIX CO		9. AGE (In years last birthday) 79	
11. BIRTHPLACE (City and state or country) LOUISIANA		12. CITIZEN OF WHAT COUNTRY? U. S. A.			
13a. FATHER'S NAME MARCELINE DUCOTE		13b. MOTHER'S MAIDEN NAME IDA BORDELON		14. NAME OF HUSBAND OR WIFE HELOISE DUCOTE (DECD)	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 497-01-3396		17. INFORMANT THERESA KOENIG Address 4123 HAVEN	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Broncho-Pneumonia. Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) Pneumophinitis. DUE TO (c) Hyp. Peustaki.					INTERVAL BETWEEN ONSET AND DEATH 2 days. 3 yrs. 0
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 610x					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) 2		
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.					
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from Mar. 5. 58. to April 1. 58. and last saw ^{her} him alive on April 1. 58. Death occurred at 7:45 P m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) Dr. H. Boock M.D.			22b. ADDRESS 1604 P. Grand Ave.		22c. DATE SIGNED 4/2/58
23a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL		23b. DATE Apr. 3 1958		23c. NAME OF CEMETERY OR CREMATORY RESURRECTION	
24. FUNERAL DIRECTOR Thomas Kutis 2906 Lewis		25. DATE RECD. BY LOCAL REG. APR 2 '58		26. REGISTRAR'S SIGNATURE Charles Smith MD M&B	

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION

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.

Student
Signature of Student Embalmer

Signed *Leo J. Budde*

Licensed Embalmer No. *3989*

P. O. Address: *St. Louis, Mo.*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.