WRITE PLAINLY, WITH UNFADING INK—THIS IS 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.

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

File No. 21235

PLACE OF DEATH

County Cape Girardeau

Township ..... Registration District No. 125

or

Village ..... Primary Registration District No. 3009 Registered No. .....

or

City Cape Girardeau (NO. 523 Broadway St.; 2 Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME Charles C. Borchers

PERSONAL AND STATISTICAL PARTICULARS

SEX: Male

COLOR OR RACE: white

SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Single

DATE OF BIRTH: Feb (Month) 15 (Day), 1862 (Year)

AGE: 53 yrs. 5 mos. 20 ds. If LESS than 1 day, ... hrs. or ..... min.?

OCCUPATION
(a) Trade, profession, or particular kind of work: Druggist
(b) General nature of industry, business, or establishment in which employed (or employer): .....

BIRTHPLACE (City or town, State or foreign country): Cape Girardeau

PARENTS
NAME OF FATHER: Hy Borchers
BIRTHPLACE OF FATHER (City or town, State or foreign country): Germany
MAIDEN NAME OF MOTHER: Matilda Burgmann
BIRTHPLACE OF MOTHER (City or town, State or foreign country): Germany

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) William F. Burgmann

(ADDRESS) Cape Girardeau Mo.

Filed July 29 1915 Clara Reed REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH: July (Month) 29 (Day), 1915 (Year)

I HEREBY CERTIFY, that I attended deceased from ....., 191..., to ....., 191...,

that I last saw h..... alive on ....., 191...,

and that death occurred, on the date stated above, at 3 00 p.m.

The CAUSE OF DEATH* was as follows:

Suicide. Shot himself on the head with a pistol
Verdict of the Jury

167 (Duration) ..... yrs. ..... mos. ..... ds.

Contributory (SECONDARY) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) E. R. Schoen Coroner ~~M.D.~~

July 29, 1915 (Address) Gordonville Mo.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

PLACE OF BURIAL OR REMOVAL: St. Louis Mo.

DATE OF BURIAL: July 30 1915

UNDERTAKER: Walther Furn. & Und. Co.

ADDRESS: Cape Girardeau Mo.

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

PLACE OF DEATH

County.....

Township ..... Registration District No..... File No.....
or
Village..... Primary Registration District No..... Registered No.....
or
City .....(NO.:..... ..... St.:.....Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME.....

WRITE PLAINLY, WITH UNFADING INK—THIS IS 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.

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	SINGLE MARRIED WIDOWED OR DIVORCED (*Write* the word)

DATE OF BIRTH

.....(Month) .....(Day), *1*.....(Year)

AGE .....yrs.....mos.....ds. | If LESS than 1 day,.....hrs. or.....min.?

OCCUPATION
(a) Trade, profession, or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) .....

BIRTHPLACE
(City or town, State or foreign country)

PARENTS

NAME OF FATHER

BIRTHPLACE OF FATHER
(City or town, State or foreign country)

MAIDEN NAME OF MOTHER

BIRTHPLACE OF MOTHER
(City or town, State or foreign country)

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant).....

(ADDRESS).....

Filed ...., 191....., ...
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH

....., *191*.....
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from .....,191....., to.....,191.....,
that I last saw h.....alive on.....,191.....,
and that death occurred, on the date stated above, at.....m.
The CAUSE OF DEATH* was as follows:

.....

.....

.....(Duration).....yrs.....mos.....ds.

Contributory.....
(SECONDARY)
.....(Duration).....yrs.....mos.....ds.

(Signed)..... M. D.

....., 191..... (Address).....

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted If not at place of death? .....

Former or usual residence.....

PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
	....., 191.....
UNDERTAKER	ADDRESS