...E PLAINLY, WITH UNFADING INK...

B.—Every item of information should be carefully supplied. AGE should be stated ... SICIANS 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

PLACE OF DEATH

County Shelby

Township Blackcreek

or

Village

or

City (NO. St.; Ward)

Registration District No. 831 File No. 11781

Primary Registration District No. 6072 Registered No. 6

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

FULL NAME Joseph Edward Borum

PERSONAL AND STATISTICAL PARTICULARS

SEX: Male

COLOR OR RACE: White

SINGLE MARRIED WIDOWED OR DIVORCED (Write the word): Widower

DATE OF BIRTH: March (Month) 14 (Day), 1861 (Year)

AGE: ~~48~~ 57 yrs. 0 mos. 10 ds.

If LESS than 1 day, ___ hrs. or ___ min.?

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

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

BIRTHPLACE (City or town, State or foreign country): Dewitt Co Ill

PARENTS

NAME OF FATHER: Aaron Bourm

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

MAIDEN NAME OF MOTHER: Sarah J Winkel

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

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Martha O Daniel

(ADDRESS) Shelbina Mo

Filed 3-24, 1918 Wm Carson REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH: Mch 24 (Month) (Day), 1918 (Year)

I HEREBY CERTIFY, that I attended deceased from Mch 21, 1918, to Mch 24, 1918, that I last saw him alive on Mch 23, 1918, and that death occurred, on the date stated above, at 2 a m.

The CAUSE OF DEATH* was as follows:

Erysipelas — 18

59

15B

(Duration) ___ yrs. ___ mos. 4 ds.

Contributory (SECONDARY) Diabetes Melitus

(Duration) 2 yrs. ? mos. ___ ds.

(Signed) P C Archer M. D.

Mch 24, 1918 (Address) Shelbyville 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: Shelbina Mo

DATE OF BURIAL: March 25, 1918

UNDERTAKER: J W Thompson & Son

ADDRESS: Shelbyville Mo

PLACE OF DEATH

County _____

Township _____
or
Village _____
or
City _____ (NO. _____, _____ St.; _____ Ward)

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

Registration District No. _____ File No. _____

Primary Registration District No. _____ Registered No. _____

[If death occurr hospital or inst give its NAME of street and num

FULL NAME _____

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 _____ (Month) _____ (Day), 1

I HEREBY CERTIFY, that I attended deceased _____, 191____, to _____, 1 that I last saw h_____ alive on _____, 1 and that death occurred, on the date stated above, at _____

The CAUSE OF DEATH* was as follows:

_____

_____

_____

_____ (Duration) _____ yrs. _____ mos. _____

Contributory _____
(SECONDARY)

_____ (Duration) _____ yrs. _____ mos. _____

(Signed) _____

_____, 191____ (Address) _____

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

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIEN RECENT RESIDENTS)

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

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

Former or usual residence _____

PLACE OF BURIAL OR REMOVAL | DATE OF BURIAL _____, 1

UNDERTAKER | ADDRESS