

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

Do not use this space.

25 1930

1. PLACE OF DEATH

County St. Louis Registration District No. 314
 Township F Primary Registration District No. 4190
 City St. Louis (No. _____) St. _____ Ward _____

File No. 4618
 Registered No. 7

2. FULL NAME Marie Louise Borron
 (a) Residence. No. St. Louis Mo. St. 2147 A Lafayette
 (Usual place of abode) (If nonresident, give city or town and State)
 Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F **4. COLOR OR RACE** W **5. SINGLE, MARRIED, WIDOWED OR DIVORCED** (write the word) married
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Calvin R Borron
6. DATE OF BIRTH (MONTH, DAY AND YEAR) NOV-2-1892
7. AGE YEARS 36 MONTHS 3 DAYS 7 If LESS than 1 day, _____ hrs. or _____ min.

8. OCCUPATION OF DECEASED
 (a) Trade, profession, or particular kind of work Housewife
 (b) General nature of industry, business, or establishment in which employed (or employer)
 (c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) St. Louis MO
 (STATE OR COUNTRY)

10. NAME OF FATHER Frederick
11. BIRTHPLACE OF FATHER (CITY OR TOWN) Germany
 (STATE OR COUNTRY)
12. MAIDEN NAME OF MOTHER Walt
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Germany
 (STATE OR COUNTRY)

14. INFORMANT Calvin R. Borron
 (Address) 2147 A Lafayette St. St. Louis Mo

15. FILED 2/11 1930 W. H. Bennett REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Feb. 9 1930
17. I HEREBY CERTIFY, That I attended deceased from Jan. 8 1930 to Jan. 9 1930
 that I last saw her alive on Jan. 9 1930, and that death occurred, on the date stated above, at 8:30 a m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Leucemia
54-D
P7B
 (duration) _____ yrs. _____ mos. 2 ds.
CONTRIBUTORY (SECONDARY) Tumor of Brain
 (duration) 2 yrs. _____ mos. _____ ds.

18. WHERE WAS DISEASE CONTRACTED
 IF NOT AT PLACE OF DEATH.

19. DID AN OPERATION PRECEDE DEATH? No DATE OF _____
20. WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS?
 (Signed) H. H. H. H. H. M. D.
 19 _____ (Address) St. Louis, Mo.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) Whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL St. Louis MO **DATE OF BURIAL** 2/11 1930

20. UNDERTAKER Laboy & Phillips **ADDRESS** St. Louis MO

10-10-10

1-4

1015

21

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

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH.

County Genesee Registration District No. 314 File No.
 Township Stanberry Primary Registration District No. 4190 Registered No.
 City Stanberry (No.) St. Ward

2. FULL NAME Minnie Louise Borron
 (a) Residence No. St. Ward.
 (Usual place of abode) (If nonresident give city or town and State)
 Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F **4. COLOR OR RACE** W **5. SINGLE, MARRIED, WIDOWED OR DIVORCED** M
(write the word)

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

7. AGE YEARS MONTHS DAYS **IF LESS than 1 day,** hrs. or min.

8. OCCUPATION OF DECEASED

- (a) Trade, profession, or particular kind of work
 (b) General nature of industry, business, or establishment in which employed (or employer)
 (c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY)

14. INFORMANT (Address)

15. FILED 4-10-30 CS Bernat REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Feb 9 1930

17. I HEREBY CERTIFY, That I attended deceased from
 to
 that I last saw h. alive on, 19....., and that death occurred, on the date stated above, at.....m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Cerebralis
 (duration) yrs. mos. ds.
CONTRIBUTORY (SECONDARY) Tumor of Brain
Metastatic (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED
 IF NOT AT PLACE OF DEATH.....
DID AN OPERATION PRECEDE DEATH? 840 DATE OF.....
WAS THERE AN AUTOPSY?.....
WHAT TEST CONFIRMED DIAGNOSIS?.....
 (Signed)....., M. D.
 , 19 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL **DATE OF BURIAL**

20. UNDERTAKER **ADDRESS**

SUPPLEMENTARY

REGIS. FRS SHALL NOT RECEIVE A FEE F. UNLESS UNTIL THEY ARE COMPLETE

Y LAW

819H-5