

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

Do not use this space.

1. PLACE OF DEATH

County Jackson
Township Kaw
City Kansas City, Mo.

Registration District No. 399
Primary Registration District No. 1002
4529 Washington

25049

File No. _____
Registered No. 302495
St. _____ Ward _____

2. FULL NAME Carl L. Borgquist

(a) Residence No. 4529 Washington St. 7 Ward _____

(Usual place of abode) 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. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) May 27, 1863

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
68 1 15

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Supt. Mill
(b) General nature of industry, business, or establishment in which employed (or employer) _____
(c) Name of employer J.C. Nichols

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

PARENTS

10. NAME OF FATHER Unknown
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Sweden
12. MAIDEN NAME OF MOTHER Unknown
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Sweden

14. INFORMANT Oscar Borgquist
(Address) 4531 Washington

15. FILED 7/14, 31 M.M. Crowe REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 7-12-31

17. I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____ 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:

Arterio myo condition
93C
97 (duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) arterio sclerosis (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH _____

DID AN OPERATION PRECEDE DEATH? No DATE OF _____

WAS THERE AN AUTOPSY? Yes

WHAT TEST CONFIRMED DIAGNOSIS? autopsy

(Signed) Stanley M. Hall, M. D.

7/12, 1931 (Address) Deputy Coroner

*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

Mt Moriah Cemetery

DATE OF BURIAL

7-15-31 19

20. UNDERTAKER

R.V. Lindsey & Sons, Inc.

ADDRESS

K.C. Mo.

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.

