

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

27152
Do not use this space.

AUG 19 1939

1. PLACE OF DEATH

(a) County Wayne Registration District No. 308-A-65
 (b) Township Franklin Primary Registration District No. 4-2-1-7 Registered No. _____
 (c) City Des Arc (d) Street No. _____ (If death occurred in Hospital or Institution, write its name instead of street and number) St. _____
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

MARION MICHAEL BORDERS
 (a) Residence, No. _____ St. (If nonresident, give city or town and State)
 (Usual place of abode, if no street address, write county or city)

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 SADIE EATHERINE BORDERS

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) MAY 25, 1881

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
58 2 2

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. _____
 9. Industry or business in which work was done, as saw mill, bank, etc. FARMER
 10. Date deceased last worked at this occupation (month and year) _____ 11. Total time (years) spent in this occupation WIFE

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) DES ARC MISSOURI

FATHER 13. NAME MIKE BORDERS O

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) MISSOURI

MOTHER 15. MAIDEN NAME MARY ELDRIDGE

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) KENTUCKY

17. INFORMANT (ADDRESS) MRS SADIE BORDERS DES ARC Mo.

18. BURIAL, CREMATION, OR REMOVAL PLACE DES ARC CEM DATE _____ 19.

19. FUNERAL DIRECTOR (NAME) WENCKEL FUNERAL SERV (ADDRESS) IRONTON Mo.

20. FILED July 30 1939 W. R. Stevenson Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) April 29, 1939

22. I HEREBY CERTIFY, That I attended deceased from April 29, 1939, to April 29, 1939
 I last saw him alive on April 29, 1939. Death is said to have occurred on the date stated above, at 9:30 a.m.
 The principal cause of death and related causes of importance were as follows:

Far advanced Tuberculosis

Date of onset

Other contributory causes of importance:

Name of operation _____ Date of _____

What test confirmed diagnosis? _____ Was there an autopsy? _____

23. If death was due to external causes (violence), fill in also the following: Accident, suicide, or homicide? _____ Date of injury _____, 19____

Where did injury occur? _____ (Specify city or town, county, and State)
 Specify whether injury occurred in industry, in home, or in public place.

Manner of injury _____ Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? no

If so, specify _____ (Signed) W. J. Cline M.D., M. D.

(Address) Bredmont, 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.

27

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,

Geo. P. Leuchel

, or by

Registered Apprentice No., working under my personal supervision.

Signed

Geo. P. Leuchel

Licensed Embalmer No. *3475*

P. O. Address *Spouton Md.*

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 this body is not embalmed, above space should be left blank.

FILL IN ANSWERS TO ALL SPACES
CHECKED IN RED PENCIL.

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

2715-2
Do not use this space.

1. PLACE OF DEATH
 (a) County Wayne Registration District No. 65.
 (b) Township Logan Primary Registration District No. 6192 Registered No. _____
 (c) City _____ (d) Street No. _____ St. _____
 (If death occurred in Hospital or Institution, write its name instead of street and number)
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Marion Michial Bardses
 (a) Residence, No. _____ St. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

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

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.
38 2 2

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. _____
 9. Industry or business in which work was done, as saw mill, bank, etc. _____
 10. Date deceased last worked at this occupation (month and year) _____ 11. Total time (years) spent in this occupation _____

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) _____

FATHER 13. NAME _____
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) _____

MOTHER 15. MAIDEN NAME _____
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) _____

17. INFORMANT (ADDRESS) _____

18. BURIAL, CREMATION, OR REMOVAL PLACE _____ DATE _____ 19

19. FUNERAL DIRECTOR (ADDRESS) _____

20. FILED _____ 19 _____ Local Registrar.

21. DATE OF DEATH (MONTH, DAY, AND YEAR) _____, 19 _____

22. I HEREBY CERTIFY, That I attended deceased from _____, 19 _____ to _____, 19 _____
 I last saw h. _____ alive on _____, 19 _____ Death is said to have occurred on the date stated above, at _____ m.
 The principal cause of death and related causes of importance were as follows:
Fatal advanced Tuberculosis pulmonary
 Date of onset _____
 Other contributory causes of importance: 22

Name of operation _____ Date of _____
 What test confirmed diagnosis? _____ Was there an autopsy? _____

23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide? _____ Date of injury _____, 19 _____
 Where did injury occur? _____ (Specify city or town, county, and State)
 Specify whether injury occurred in industry, in home, or in public place. _____

Manner of injury _____
 Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? _____
 If so, specify _____
 (Signed) H. H. Dine _____, M. D.
 (Address) Piedmont Mo

SUPPLEMENT

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.
 CAUSE OF DEATH IN plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

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

2715-2
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1. PLACE OF DEATH

(a) County Wayne Registration District No. 68
 (b) Township Logan Primary Registration District No. 6192 Registered No. _____
 (c) City _____ (d) Street No. _____ St.
 (If death occurred in Hospital or Institution, write its name instead of street and number)
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U.S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

Marion Michael Borders
 (a) Residence, No. _____ St. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

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

21. DATE OF DEATH (MONTH, DAY, AND YEAR) July 27, 1939

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

22. I HEREBY CERTIFY, that I attended deceased from Apr 29 1939 to Apr 29, 1939

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) May 25 1881

I last saw h. alive on Apr 29, 1939 Death is said to have occurred on the date stated above, at 9:30 m.

7. AGE YEARS 58 MONTHS 2 DAYS 2 If LESS than 1 day, _____ hrs. or _____ min.

The principal cause of death and related causes of importance were as follows:

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Farmer
 9. Industry or business in which work was done, as saw mill, bank, etc. _____
 10. Date deceased last worked at this occupation (month and year) _____ 11. Total time (years) spent in this occupation _____

Death is said to have occurred on the date stated above, at _____ m.

The principal cause of death and related causes of importance were as follows:

Fat advanced tuberculosis

Date of onset

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Des Arc

Other contributory causes of importance:

FATHER 13. NAME Mike Borders

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Mo

MOTHER 15. MAIDEN NAME Mary Eldridge

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Mo

17. INFORMANT (ADDRESS) Mrs Sadie Borders
Des Arc Mo

18. BURIAL, CREMATION, OR REMOVAL

PLACE Des Arc DATE _____ 19 _____

19. FUNERAL DIRECTOR (ADDRESS) General Funeral Service
Sharon Mo

20. FILED Apr 8 19 Mrs T.M. Palk
Local Registrar.

Name of operation _____ Date of _____

What test confirmed diagnosis? _____ Was there an autopsy? _____

23. If death was due to external causes (violence), fill in also the following:

Accident, suicide, or homicide? _____ Date of injury _____, 19 _____

Where did injury occur? _____ (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury _____

Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? _____

If so, specify _____

(Signed) N. H. Clipse, M. D.

(Address) Piedmont Mo

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW. CAUSE OF DEATH IN plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

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MISSOURI STATE BOARD OF HEALTH
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CERTIFICATE OF DEATH

2715-2
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1. PLACE OF DEATH
 (a) County Wayne Registration District No. 65
 (b) Township Lryan Primary Registration District No. 6192 Registered No. _____
 (c) City _____ (d) Street No. _____
 (If death occurred in Hospital or Institution, write its name instead of street and number)
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.
2. PRINT FULL NAME Marion Michael Borders
 (a) Residence, No. _____ St. (If nonresident, give city or town and State)
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX <u>m</u>	4. COLOR OR RACE <u>w</u>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <u>m</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF		
6. DATE OF BIRTH (MONTH, DAY, AND YEAR)		
7. AGE	YEARS <u>58</u>	MONTHS <u>2</u>
		DAYS <u>2</u>
		IF LESS than 1 day, _____ hrs. or _____ min.
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.		11. Total time (years) spent in this occupation
9. Industry or business in which work was done, as saw mill, bank, etc.		
10. Date deceased last worked at this occupation (month and year)		
12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)		
13. NAME		
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)		
15. MAIDEN NAME		
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)		
17. INFORMANT (ADDRESS)		
18. BURIAL, CREMATION, OR REMOVAL PLACE DATE		
19. FUNERAL DIRECTOR (ADDRESS)		
20. FILED <u>Sept 8 1929 Mrs. T.M. Poole</u> Local Registrar		

21. DATE OF DEATH (MONTH, DAY, AND YEAR) July 27, 1939

22. I HEREBY CERTIFY, that I attended deceased from _____ to _____, 19____.

I last saw h. _____ alive on _____, 19____. Death is said to have occurred on the date stated above, at _____ m.

The principal cause of death and related causes of importance were as follows:

Other contributory causes of importance:

Name of operation _____ Date of _____

What test confirmed diagnosis? _____ Was there an autopsy? _____

23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide? _____ Date of injury _____, 19____.
 Where did injury occur? _____ (Specify city or town, county, and State)
 Specify whether injury occurred in industry, in home, or in public place.

Manner of injury _____
 Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? _____
 If so, specify _____
 (Signed) H. H. Alene, M. D.
 (Address) Fieldmont

SUPPLEMENTARY

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW. Every return of mortality should be carefully supervised, and should be stated in plain terms, so that it may be properly classified. Exact statement of OCCUR CAUSE OF DEATH in plain terms, so that it may be properly classified. f is very important.