

FILED APR 23 1940
Registration District No. **533**

Primary Registration District No. **5721**

Registrar's No. **17**

1. PLACE OF DEATH:

(a) County **Marion Co. Mo.**
(b) City or town **Round Grove**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **none**
(Specify whether)

In this community
years, months or days

8. (a) PRINT FULL NAME **WILLIAM M BORK 620**

3. (b) If veteran, name war **none** 3. (c) Social Security No. **none**

4. Sex **Male** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **Widow**

6. (b) Name of husband or wife **Ida** 6. (c) Age of husband or wife if alive **deceased** years

7. Birth date of deceased **Oct 15 1866**
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	73	4	29	hr. min.

9. Birthplace (City, town, or county) (State or foreign country)

10. Usual occupation **Livingston Co Ill**

11. Industry or business **Farming**

12. Name **Carl Bork 6**

13. Birthplace (City, town, or county) (State or foreign country) **Germany**

14. Maiden name **Ida**

15. Birthplace (City, town, or county) (State or foreign country) **Germany**

16. (e) Informant **Eleanor Bork**

(b) Address **Arabel Mrs Moore**

17. (a) **Burial** (b) Date thereof **3 16 1940**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Bethel Home Co**

18. (a) Signature of funeral director **William Bork**

(b) Address **Shelby & Clarence**

19. (a) **4/1/40** (b) **Clarence**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo** (b) County **Marion**
(c) City or town **Rural** (If outside city or town limits, write "RURAL")
(d) Street No. (If rural, give location)
(e) If foreign born, how long in U. S. A. years

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **March** day **14**
year **1940** hour **3** minute **45** p.m.

21. I hereby certify that I attended the deceased from **Feb 19 40** to **March 1940**
that I last saw him alive on **Mar 14 1940**
and that death occurred on the date and hour stated above.

Immediate cause of death **Cerebral apoplexy** Duration **2 day**

Due to **hypertension** **5 YB**

Due to **none**

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations **none**

Of autopsy **none**

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) **no**

(b) Date of occurrence **no**

(c) Where did injury occur? (City or town) (County) (State) **no**

(d) Did injury occur in or about home, on farm, in industrial place, in public place? **no**

While at work? **no** (Specify type of place) (e) Means of injury **no**

23. Signature **Dr. L. Harlan** **MAR 15 1940**
Address **Clarence** (M. D. or other) **MD**
Date signed

PHYSICIAN
Underline the cause to which death should be charged statistically.

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

RECEIVED

District Health Officer No. 10

District File Number 4-40-724

Date Filed APR 9 1940

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, or by

..... Registered Apprentice No.

working under my personal supervision.

Signed *Henry A. Berkeley*

Licensed Embalmer No. 3835

P. O. Address *Shelburne, Mo.*

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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 11653

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. 533

Primary Registration District No. 5721

Registrar's No.

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(a) County Macon
(b) City or town Round Grove Ins
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:

(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether
In this community _____ years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____
(c) City or town _____ (If outside city or town limits write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years.

3. (a) PRINT FULL NAME Wm M Bark

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex m 5. Color or race w 6. (a) Single, widowed, married, divorced wid

6. (b) Name of husband or wife _____ 6. (c) Age of husband, or wife, if alive _____ year

7. Birth date of deceased. (Month) (Day) (Year)

8. AGE: Years 73 Months 4 Days 29 If less than one day _____ hr _____ min.

9. Birthplace Livingstone Co., Va. (City, town, or county) (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

12. Name _____

13. Birthplace (City, town, or county) (State or foreign country)

14. Maiden name _____

15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) 4/2/40 (b) Clarence M. ... (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH Month Mar day 14 year _____ hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____; that I last saw him _____ alive on _____ and that death occurred on the date and hour stated above.

Immediate cause of death _____

Due to _____

Due to _____

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy _____

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work _____ (Specify type of place) (e) Means of injury _____

23. Signature D. L. Harlow (M. D. or other)

Address Clarence M. ... Date signed _____

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

SUPPLEMENTARY

11653 (1940)