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14 1941

District No. 317 317

Primary Registration District No. 4192

Registrar's No. _____

1. PLACE OF DEATH:

(a) County **GREENE**
(b) City or town **Springfield Republic MO**
(c) Name of hospital or institution:
Republic MO
(d) Length of stay: In hospital or institution _____
In this community **55 years 1** (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Greene**
(c) City or town **Republic MO**
(d) Street No. _____
(e) Citizen of foreign country? (or No)
If yes, name country _____

3. (a) PRINT FULL NAME **Abner Cope DeBorde**

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

4. Sex **M** 5. Color or race **W** 6. (a) Single, widowed, married, divorced **Married**
6. (b) Name of husband or wife **Matha West DeBorde** 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased: **Mar 5 1865** (Month) (Day) (Year)

8. AGE: Years **76** Months **4** Days **24** If less than one day _____ hr. _____ min.

9. Birthplace **Level Greene K.Y.** (City, town, or county) (State or foreign country)

10. Usual occupation **Stockman**

11. Industry or business _____

MOTHER FATHER { 12. Name **Abner Cope DeBorde**
13. Birthplace **Level Greene K.Y.**
14. Maiden name **Susan Swell**
15. Birthplace **N.C.**

16. (a) Informant **Mrs G. L. DeBorde**
(b) Address **Republic MO**

17. (a) **Burial** (b) Date thereof _____
(c) Place: burial or cremation _____

18. (a) Signature of funeral director **Quinn Funeral Home**
(b) Address **629 W Walnut**

19. (a) **July 5** (b) **Mrs Bertha Nance**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **July** day **1** year **1941** hour **4** minute **30 P.M.**

21. I hereby certify that I attended the deceased from **June 17** 1941 to **July 1** 1941 that I last saw him alive on **July 1st 1941** and that death occurred on the date and hour stated above.

Immediate cause of death **acute septicaemia**

Due to **senile**

Other conditions _____

Major findings: Of operations **MI**
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? _____
(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

23. Signature **Dr. R. M. Miller** (Specify type of place) (e) M.D. or other **MD**
Address **Republic MO** Date signed _____

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

RECEIVED
Greene County Health Office,
County File Number 41-8-81
Date Filed 8/7/91

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 Floyd W. Fox
Licensed Embalmer No 2910
P. O. Address 629 W. Wolan

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to complete the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 25072

Registration District No. 317

Primary Registration District No. 4192

Registrar's No.

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

1. PLACE OF DEATH

(a) County Greene

(b) City or town Republic
(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)

3. (a) PRINT FULL NAME Abner C. De Borde

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 M

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

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

8. AGE: Years _____ Months _____ Days _____ If less than one day _____ min.

9. Birthplace _____ (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) Burial (b) Date thereof July 4 - 1941
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Evergreen Cemetery

18. (a) Signature of funeral director Dubony Funeral Home

(b) Address 629 W. Walnut Springfield Mo

19. (a) July 4 (b) Mrs Beltha Mance
(Date received local registrar) (Registrar's signature)

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) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July Day _____ Year 1941 Hour _____ Minute _____ M.

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

Immediate cause of death _____ Duration _____

Due to _____

Due to _____

Other conditions _____ (Include pregnancy within 3 months of death)

Major findings: _____ PHYSICIAN _____
Of operations _____
Of autopsy _____
Underline the cause to which death should be charged statistically.

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

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

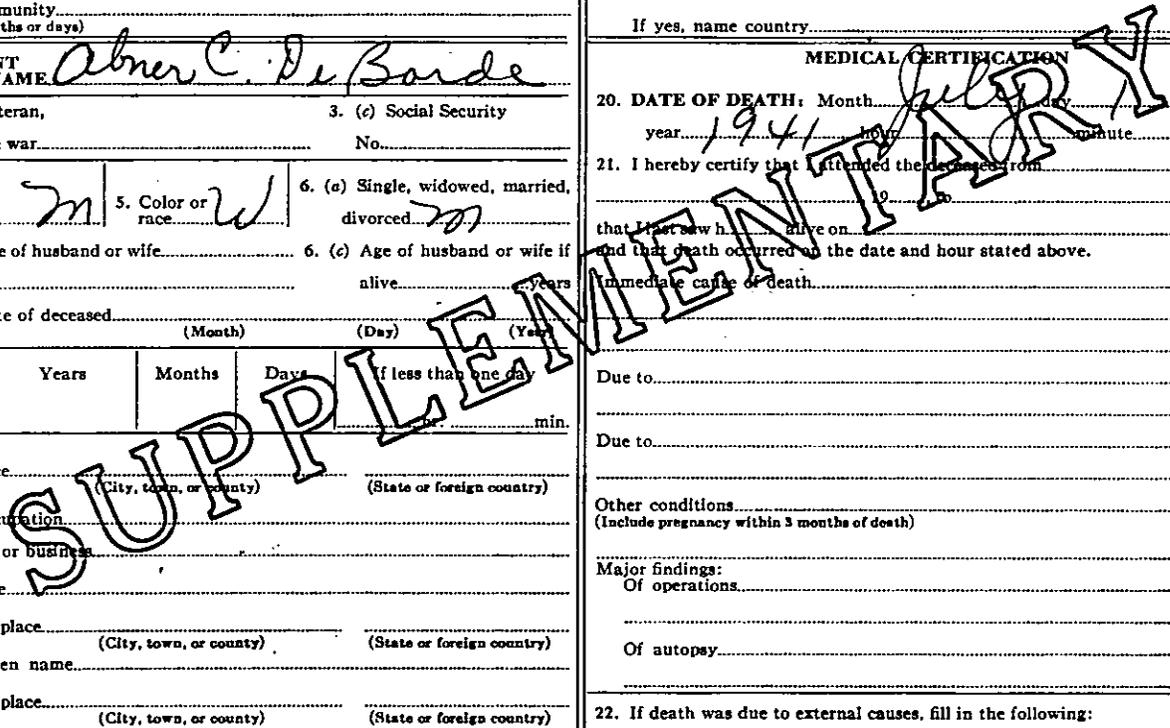
(b) Date of occurrence _____

(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 _____ (M. D. or other) _____
Address _____ Date signed _____



MOTHER FATHER

etc

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 25072

Registration District No. 317

Primary Registration District No. 4192

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Greene

(b) City or town Republic Mo.
(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 55 yrs 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) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Abner Cope De Borde

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July Day _____
Year 1941 Hour _____ Minute _____ M.

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

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

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

7. Birth date of deceased mar 5, 1865
(Month) (Day) (Year)

8. AGE: Years 76 Months 4 Days 1 If less than one day min.

9. Birthplace _____
(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 _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) _____
(Date received local registrar) (Registrar's signature)

Duration _____

Due to acute nephritis

Due to service

Other conditions chronic nephritis
(Include pregnancy within 3 months of death)

Major findings: _____

Of operations _____

Of autopsy _____

PHYSICIAN 1318
Underline the cause to which death should be charged statistically.

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)
Means of injury _____

23. Signature [Signature] (M.D. or other) D.O.
Address Republic Mo Date signed _____

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

SUPPLEMENTARY