No. 2
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
N 2 2 1942

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 40927

Registration District No. 399 Primary Registration District No. 1002 Registrar's No. 4605

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

1. PLACE OF DEATH:

(a) County Jackson

(b) City or town Kansas City, Mo. (If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: 2823 Oakley (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution -- (Specify whether

In this community 2 months / years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson 048

(c) City or town Kansas City, Mo. (If outside city or town limits, write "RURAL")

(d) Street No. 2823 Oakley (If rural, give location)

(e) If foreign born, how long in U. S. A.? 10 years.

3. (a) PRINT FULL NAME Karen Sue Borders

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

4. Sex F 1 5. Color or race W 6. (a) Single, widowed, married, divorced 0 --

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

7. Birth date of deceased Oct. 1st, 1941 (Month) (Day) (Year)

8. AGE: Years | Months 2 | Days 10 | If less than one day ___ hr. ___ min.

9. Birthplace Kansas City, Mo. (City, town, or county) 0 (State or foreign country)

10. Usual occupation -- None

11. Industry or business --

FATHER
12. Name Paul Borders
13. Birthplace (City, town, or county) Glacow, Ky 1 (State or foreign country)

MOTHER
14. Maiden name Anna Schroyer
15. Birthplace (City, town, or county) Kansas City, Mo. 0 (State or foreign country)

16. (a) Informant Paul Borders
(b) Address 2823 Oakley, K.C.Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 13th-41 (Month) (Day) (Year)
(c) Place: burial or cremation Mt Washington Cem.

18. (a) Signature of funeral director Sheil Funeral Home
(b) Address 6606 Indep. Ave. K.C.Mo.

19. (a) Dec. 12, 1941 (Date received local registrar) (b) M. M. Crowe (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec. day 11th year 1941 hour 2 minute 30 P M.

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

Immediate cause of death Alfred Cerone

Due to Staters thymocolymphaticus

Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations 64

Of autopsy

Duration

PHYSICIAN

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? (Specify type of place)
While at work? Means of injury 3

23. Signature [signature] (M. D. or other)
Address K.C. Mo. Date signed

(Licensed Embalmer's Statement on Reverse Side)

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.....

Licensed Embalmer No.....

P. O. Address.....

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

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