

FILED FEB 11 1942

State File No. _____

Registration District No. 399

Primary Registration District No. 1002

Registrar's No. 415

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

1. PLACE OF DEATH:

(a) County Jackson
 (b) City or town Kansas City
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution K.C. General Hospital No. 1
(If not in institution, write street number or location)
 (d) Length of stay: In hospital or institution 1 1/2 hr.
Seen by visiting physicians from hospital
 In this community in home on 1-29-42
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson
 (c) City or town Kansas City
(If outside city or town limits, write "RURAL")
 (d) Street No. 1012 Olive
(If rural, give location)
 (e) Citizen of foreign country? _____ (Yes or No)
 If yes, name country _____

3. (a) PRINT FULL NAME Ed Border

(b) If veteran, name war --- (c) Social Security No. 70

4. Sex M. 5. Color or race W. 6. (a) Single, widowed, married, divorced Married

7. Birth date of deceased Jan 13th 1869
(Month) (Day) (Year)

8. AGE: Years 73 Months --- Days 17 If less than one day _____ hr. _____ min.

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

10. Usual occupation None

11. Industry or business _____

MOTHER FATHER

12. Name George R. Border

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

14. Maiden name Delliah Moore

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

16. (a) Informant Record Clerk

(b) Address K.C. Gen. Hospital

17. (a) Burial (b) Date thereof 1-30-42
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Clinton Mo

18. (a) Signature of funeral director Wilkinson Fun Home

(b) Address Clinton, Mo

19. (a) 1/30/42 (b) M. M. Brown
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan. day 30th
 year 1942 hour 10 minute A.M. M.

21. I hereby certify that I attended the deceased from _____
1-30-42 19____ to 1-30-42 19____;
 that I last saw him alive on 1-30-42 19____;
 and that death occurred on the date and hour stated above.

Immediate cause of death: Right lower lobar pneumonia; acute and chronic coronary occlusion

Due to _____

Due to 108

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

Major findings: _____
 Of operations _____

Of autopsy See above

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? _____ (e) Means of injury _____

23. Signature Mary R. Han (M, D, or other) _____
 Address Ind. Div. K.C. Gen. Hospital 1-30-42
Date signed

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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 with 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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

State File No.

Registration District No. 399

Primary Registration District No. 1002

Registrar's No. 415

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

1. PLACE OF DEATH: Jackson
 (a) County.....
 (b) City or town..... Kennett City
 (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.....
 In this community..... (Specify whether
 years, months or days)

3. (a) PRINT FULL NAME Edward Border

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

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

6. (b) Name of husband or wife..... Mary J Border 6. (c) Age of husband, or wife, if alive..... 70 years

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

8. AGE:	Years	Months	Days	If less than one day
			h.....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) 2/13/42 (b) M. M. Brown (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) If foreign born, how long in U. S. A.?..... years.

MEDICAL CERTIFICATION
 20. DATE OF DEATH..... Month..... day..... 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..... (M. D. or other).....

Address..... Date signed.....

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

SUPPLEMENTARY

5-1096