

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **31186**

Registrar's No. **890**

Registration District No. **42**

Primary Registration District No. **1000**

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

1. PLACE OF DEATH:

(a) County Buchanan
 (b) City or town St. Joseph
 (c) Name of hospital or institution:
615 South 19th
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution. no
 In this community 60 Years (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Buchanan
 (c) City or town St. Joseph
 (d) Street No. 615 South 19th
 (e) Citizen of foreign country? no (Yes or No)
 If yes, name country 0

3. (a) PRINT FULL NAME JACOB CHARLES BORKOWSKI
 (b) If veteran, name war no
 (c) Social Security No. _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 2
 year 1943 hour 10 minute 30 P.M.

4. Sex Male 5. Color or race White
 6. (a) Single, widowed, married, divorced, Widowed
 (b) Name of husband or wife Gertrude Borkowski
 (c) Age of husband or wife if alive --- years
 7. Birth date of deceased September 29 1877
 (Month) (Day) (Year)

21. I hereby certify that I attended the deceased from 5 Aug 1942 to 2 Aug 1943
 that I last saw him alive on 2 Aug 1943
 and that death occurred on the date and hour stated above.

8. AGE: Years Months Days If less than one day
65 10 3 hr. min.

Immediate cause of death Cerebral hemorrhage, apoplexy
 Due to Senility

9. Birthplace Rushville Missouri
 (City, town, or county) (State or foreign country)
 10. Usual occupation Groceryman 1902 Messane
 11. Industry or business Self

Due to Senility
 Other conditions Jaundice
 (Include pregnancy within 3 months of death)

MOTHER FATHER { 12. Name William Borkowski
 13. Birthplace Germany
 (City, town, or county) (State or foreign country)
 14. Maiden name Sophia Ann Koch
 15. Birthplace Unknown
 (City, town, or county) (State or foreign country)

Major findings: None
 Of operations None
 Of autopsy None
 PHYSICIAN _____
 Underline the cause to which death should be charged statistically.

16. (a) Informant Miss Marjorie Borkowski
 (b) Address 615 South 19th, St. Joseph,
Burial (c) Date thereof Aug 7 43
 (Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation Mt. Olive Cemetery
 18. (a) Signature of funeral director Norman W. Sidin
 (b) Address 1802 Union, St. Joseph, Mo.
 19. (a) 8/17/43 (b) W. Steigog
 (Date received/local registrar) (Registrar's signature)

22. If death was due to external causes, fit 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, or public place?
 While at _____ (Specify type of place)
 (a) Means of injury _____
 23. Signature W. Steigog (M. D. or other) _____
 Address St. Joseph, Mo. Date signed 5 Aug 43

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Handwritten notes, possibly a signature or address, written upside down.

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 John H. Hurley
Licensed Embalmer No. 4050
P. O. Address St Joseph 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, fact should be so stated above.