

Registration District No. \_\_\_\_\_

Primary Registration District No. **1003**

Registrar's No. **11875**

**1. PLACE OF DEATH:**

(a) County St. Louis

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

(c) Name of hospital or institution:  
1616 Franklin Ave.  
(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 Missouri (b) County 000  
12

(c) City or town St. Louis  
(If outside city or town limits, write "RURAL") 625

(d) Street No. 1616 Franklin Ave.  
(If rural, give location)

(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

**3. (a) PRINT FULL NAME** John F. Borges

3. (b) If veteran, name war None

3. (c) Social Security No. Unknown

**MEDICAL CERTIFICATION**

20. **DATE OF DEATH:** Month Dec. day 17  
year 1943 hour 2 minute 30 P. M.

4. Sex Male

5. Color or race White

6. (a) Single, widowed, married, divorced Single

6. (b) Name of husband or wife \_\_\_\_\_

6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased May 13 1878  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, 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 \_\_\_\_\_

**8. AGE:**

Years	Months	Days	If less than one day
<u>65</u>	<u>7</u>	<u>43</u>	hr. _____ min. _____

Due to Broncho Pneumonia

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

Due to 107

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

10. Usual occupation Unknown

11. Industry or business \_\_\_\_\_

**MOTHER FATHER**

12. Name John F. Borges, Sr.

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

14. Maiden name Sophie Miller

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

**PHYSICIAN**

Major findings:  
Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

Underline the cause to which death should be charged statistically.

16. (a) Informant Mrs. Albert Wilhelm

(b) Address 610 E. 4th St. Alton, Ill.

17. (a) Removal (b) Date thereof 12-30-43  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Litchfield, Ill.

18. (a) Signature of funeral director Albert H. Hoppe, Inc.

(b) Address 4700 Washington Ave.

19. (a) DEC 30 1943 (b) J. F. Budeck  
(Date received local registrar) (Registrar's signature)

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)

(a) While at work? \_\_\_\_\_ (c) Means of injury \_\_\_\_\_

23. Signature Thomas F. Callahan (M.D. or other) 3  
Address Deputy Coroner Date signed 7-30

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

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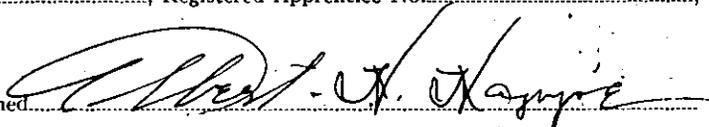
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**STATEMENT BY LICENSED EMBALMER**

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. 1861.....

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.**