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Registration District No. Primary Registration District No. Registrar's No.

1. PLACE OF DEATH:

(a) County.....

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

(c) Name of hospital or institution:
St. Louis City Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 34 days
(Specify whether years, months or days) 60 Years.

3. (a) PRINT FULL NAME Bohn Morton Borgmann

3. (b) If veteran, name war None

3. (c) Social Security No. 492-07-4030

4. Sex Male 5. Color or race White

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

6. (b) Name of husband or wife Mary Borgmann

6. (c) Age of husband or wife if alive 55 years

7. Birth date of deceased Nov. 5. 1880
(Month) (Day) (Year)

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

63	2	28	hr. min.
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9. Birthplace Germany 4
(City, town, or county) (State or foreign country)

10. Usual occupation Warehouseman

11. Industry or business Orchard Paper Co.

12. Name Henry Borgmann

13. Birthplace Germany 4
(City, town, or county) (State or foreign country)

14. Maiden name Anna Ortwerth

15. Birthplace Germany 4
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Mary Borgmann

(b) Address 4360 Desoto Ave.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/7/44
(Month) (Day) (Year)

(c) Place: burial or cremation Calvary Cemetery

18. (a) Signature of funeral director J. F. Brueck

(b) Address 2117 E. Grand Blvd.

19. (a) FEB 4 1944 (Date received local health officer) (b) J. F. Brueck (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County.....

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

(d) Street No. 4360 Desoto Ave.
(If rural, give location)

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb. day 3rd year 1944 hour 8 minute 05 PM.

21. I hereby certify that I attended the deceased from Jan. 18th 1944, to Feb. 3rd 1944; that I last saw h. im. alive on Feb. 3rd 1944; and that death occurred on the date and hour stated above.

Immediate cause of death Saangrene of lower extremities & suppurative arthritis

Due to Diabetes

Other conditions 61
(Include pregnancy within 3 months of death)

Major findings:
Of operations.....

Of autopsy.....

22. If death was due to external causes, fill in 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 W. H. Wade (M. D. or other) 2/4/44
Address 1515 Lafayette Date signed

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

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.....

Frank A. Moore

Licensed Embalmer No.....

3041

P. O. Address.....

2117 E. Main

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.