

**FILED** APR 9 1946

Registration District No. **163**

Primary Registration District No. **5596**

Registrar's No. **19**

**1. PLACE OF DEATH:**  
 (a) County: **Jefferson**  
 (b) City or town: **Wdille**  
(If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution:  
**De Soto Mt 2**  
(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 yrs.**  
years, months or days)

**2. USUAL RESIDENCE OF DECEASED:**  
 (a) State: **Mo.** (b) County: **Jefferson**  
 (c) City or town: **Summit Park**  
(If outside city or town limits, write "RURAL")  
 (d) Street No.: **Rural**  
(If rural, give location)  
 (e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
 If yes, name country: \_\_\_\_\_

**3. (a) PRINT FULL NAME:** **Albert Borchardt**  
 3. (b) If veteran, name war: **World War 1**  
 3. (c) Social Security No.: **493-05-5645**

4. Sex: **Male** 5. Color or race: **white**  
 6. (a) Single, widowed, married, divorced: **divorced**  
 6. (c) Age of husband or wife if alive: \_\_\_\_\_ years  
 6. (e) Age of husband or wife if deceased: **9** years  
 7. Birth date of deceased: **Sept. 9 1893**  
(Month) (Day) (Year)

**8. AGE:**  
 Years: **52** Months: **6** Days: **13**  
 If less than one day: \_\_\_\_\_ hr. \_\_\_\_\_ min.

**9. Birthplace:** **St. Louis Mo. D**  
(City, town, or county) (State or foreign country)

**10. Usual occupation:** **Porter**

**11. Industry or business:**

**12. Name:** **Henry Borchardt**  
**13. Birthplace:** **Germany**  
(City, town, or county) (State or foreign country)  
**14. Maiden name:** **Frieda Haas**  
**15. Birthplace:** **Germany**  
(City, town, or county) (State or foreign country)

**16. (a) Informant:** **Frieda Wolgast**  
 (b) Address: **3909 Oleath**

**17. (a) (Burial, cremation, or removal):** **Burial** (b) Date thereof: **3-26-46**  
(Month) (Day) (Year)  
 (c) Place: burial or cremation: **National Cem.**

**18. (a) Signature of funeral director:** **Witt Bros. L. Mo.**  
 (b) Address: **2929 S. Jefferson A.**

**19. (a) (Date received local registrar):** **4/3/46** (b) (Registrar's signature): **Marie Harris**

**MEDICAL CERTIFICATION**

**20. DATE OF DEATH:** Month: **Mar.** day: **22** year: **1946** hour: \_\_\_\_\_ minute: \_\_\_\_\_ M.

**21. I hereby certify that I attended the deceased from** **Mar 22 1946** to **Mar 22 1946**  
 that I last saw him alive on **Mar 22 1946**  
 and that death occurred on the date and hour stated above.

Immediate cause of death: **Coronary thrombosis**

Due to: **arteriosclerosis**

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)  
 (c) Means of injury: \_\_\_\_\_

**23. Signature:** **J. P. Higel** (M.D. or other)  
 Address: **De Soto, Mo** Date signed: **3/25/46**

Duration: **1 day**  
 Physician: \_\_\_\_\_  
 Underline the cause to which death should be charged statistically.

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

RECEIVED  
District Health Officer No. 9,  
District File Number.....  
Date Filed 4-8-46

APR 10 1946

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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..... *Donnell B. [Signature]* .....

Licensed Embalmer No. 4104 .....

P. O. Address Adato No. .....

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.

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUSTHE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATHState File No. AprilRegistration District No. 163Primary Registration District No. 5596Registrar's No. 19

## 1. PLACE OF DEATH:

(a) County Jefferson  
(b) City or town Rural  
(If outside city or town limits, write "RURAL" and name of township)  
(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. (Specify whether

In this community  
years, months or days)3. (a) PRINT  
FULL NAME Albert Boichard

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

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

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

7. Birth date of deceased Sept 9 (Month) (Day) (Year)8. AGE: Years 52 Months \_\_\_\_\_ Days \_\_\_\_\_ (Unless than one day) hr. \_\_\_\_\_ min.9. Birthplace Mo (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 \_\_\_\_\_13. (a) Signature of funeral director \_\_\_\_\_  
(b) Address \_\_\_\_\_19. (a) \_\_\_\_\_ (b) Marie Harris  
(Date received local registrar) (Registrar's signature)

## 2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County Jefferson  
(c) City or town Summit Park Rural  
(If outside city or town limits, write "RURAL")  
(d) Street No. Highway 61 (If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

## MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March 2  
year 1944 hour \_\_\_\_\_ minute \_\_\_\_\_ M.21. I hereby certify that I attended the deceased from \_\_\_\_\_ to \_\_\_\_\_, 19\_\_\_\_;  
that I last saw him/her alive on \_\_\_\_\_, 19\_\_\_\_;  
and that death occurred on the date and hour stated above.  
Immediate cause of death \_\_\_\_\_

Duration

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)Major findings:  
Of operations \_\_\_\_\_

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

## 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?While at work? \_\_\_\_\_ (Specify type of place)  
(e) Means of injury \_\_\_\_\_23. Signature \_\_\_\_\_ (M. D. or other)  
Address \_\_\_\_\_ Date signed \_\_\_\_\_

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

SUPPLEMENTARY

9885