

THE DIVISION OF HEALTH OF MISSOURI
FILED MAY 12 1949 STANDARD CERTIFICATE OF DEATH

State File No. **11909**

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

BIRTH NO. _____ REG. DIST. NO. **82** PRIMARY REG. DIST. NO. **3017** Registrar's No. **49**

1. PLACE OF DEATH a. COUNTY COOPER		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE MISSOURI b. COUNTY COOPER	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN BOONVILLE		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN (RURAL) NORTH MONTEAU	
d. FULL NAME OF HOSPITAL OR INSTITUTION ST JOSEPH HOSPITAL		d. STREET ADDRESS (If rural, give location) PRAXIE HOME MO.	
3. NAME OF DECEASED (Type or Print) a. (First) MARY b. (Middle) DALE c. (Last) BORTS			4. DATE OF DEATH (Month) (Day) (Year) APRIL 26 1949
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) NEVER MARRIED	8. DATE OF BIRTH AUG 4 1944
9. AGE (In years last birthday) 4		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CHILD	11. BIRTHPLACE (State or foreign country) MISSOURI
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CHILD		10b. KIND OF BUSINESS OR INDUSTRY	12. CITIZEN OF WHAT COUNTRY? US
13a. FATHER'S NAME DANIEL BORTS		13b. MOTHER'S MAIDEN NAME VIOLA BRIZENDINE	14. NAME OF HUSBAND OR WIFE CHILD
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. No	17. INFORMANT'S SIGNATURE OR NAME Dan Borts ADDRESS PRAXIE HOME MO.
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Pneumonia (virus) INTERVAL BETWEEN ONSET AND DEATH 12 mo. ANTECEDENT CAUSES Measles DUE TO (b) _____ DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from 4/26/49 , to 4/26 , 19 49 , that I last saw the deceased alive on 4/26 , 19 49 , and that death occurred at Praxie Home from the causes and on the date stated above.			
23a. SIGNATURE (Degree or title) M. L. Desrochers M.D.		23b. ADDRESS Boonville Mo	23c. DATE SIGNED 4/27/49
24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	24b. DATE APRIL 28 1949	24c. NAME OF CEMETERY OR CREMATORY MT. ZION CEM.	24d. LOCATION (City, town, or county) (State) MONTEAU Co. MO.
DATE REC'D BY LOCAL REG. Apr 27-49	REGISTRAR'S SIGNATURE D. Hooper	25. FUNERAL DIRECTOR'S SIGNATURE 381	ADDRESS 6. Albert Hornbeck Praxie Home MO

RECEIVED

District Health Officer No. 8,

District File Number _____

Date Filed 5-11-49

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 _____

Student Embalmer No. _____

working under my personal supervision.

Student _____
Student Embalmer

Signed C. Albert Hornbeck

Licensed Embalmer No. 2714

P. O. Address Prairie Home 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.