

No. 300
10-48

KC214 678 831 1951
REC #88290
FILED #PAR90

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 7038

BIRTH NO. _____ REG. DIST. NO. 317 PRIMARY REG. DIST. NO. 6076 Registrar's No. 543

1. PLACE OF DEATH a. COUNTY ST. LOUIS			2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE ILLINOIS b. COUNTY		
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN JEFFERSON BARRACKS, MO.		c. LENGTH OF STAY (In this place) 133 days	c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN WOODLAWN		2120
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION VET. ADM. HOSP.			d. STREET ADDRESS (If rural, give location) NONE		

3. NAME OF DECEASED (Type or Print) JOE	a. (First)	b. (Middle) (NMI)	c. (Last) BOROWIAK	4. DATE OF DEATH FEBRUARY 27, 1951	Date (Month) (Day) (Year)
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5. SEX M	6. COLOR OR RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) MARRIED	8. DATE OF BIRTH 3-10-1892	9. AGE (In years last birthday) 58	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours	Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) LA SALLE, ILLINOIS		12. CITIZEN OF WHAT COUNTRY? USA	
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13a. FATHER'S NAME JOSEPH BOROWIAK		13b. MOTHER'S MAIDEN NAME AGNES SCHMIDT		14. NAME OF HUSBAND OR WIFE JOSEPHINE BOROWIAK	
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year date of service) YES WWI	16. SOCIAL SECURITY NO. UNK.	17. INFORMANT'S SIGNATURE OR NAME VA HOSPITAL RECORDS		ADDRESS	
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)	MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) CHONDRO SARCOMA, FEMUR LEFT WITH METASTASES					
*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.	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 checked="" type="checkbox"/> NO <input type="checkbox"/>
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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)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute) VA	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from 10-16-1950, to 2-27-1951, that I am the deceased's physician and that death occurred at 7:10 AM, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) MD	23b. ADDRESS VAH JEFF., BRKS., MO.	23c. DATE SIGNED 2-27-51
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24a. BURIAL, CREMATION, REMOVAL	24b. DATE 2-28-51	24c. NAME OF CEMETERY OR CREMATORY ST. MICHEALS CEMETERY	24d. LOCATION (City, town, or county) (State) RADOM, ILLINOIS
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DATE REC'D BY LOCAL REG. 2-28-51	REGISTRAR'S SIGNATURE Herbert R. Donke MD	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS LEN HOGAN, ASHLEY, ILLINOIS
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

4000

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 *Robert M Murray*

Licensed Embalmer No. *37490*

P. O. Address *St. Louis, 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.