

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-043679  
STATE FILE NUMBER

FILED JAN 6 1959 Registration District No. 107 Primary Registration District No. 3019 Registrar's No. 200

1. PLACE OF DEATH a. COUNTY <b>Dunklin</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>New Madrid</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Kennett</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>Gideon</b> c. 720
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Presnell Hospital</b>		Length of stay in lb <b>1 Week</b>	d. STREET ADDRESS (If outside, give location) <b>Gen. Delawry</b>
Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			

3. NAME OF DECEASED (Type or print) First Middle Last <b>Blanche Marie Borders</b>			4. DATE OF DEATH Month Day Year <b>12 18 1958</b>	
--	--	--	---	--

5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9-27-1917</b>	9. AGE (In years last birthday) <b>41</b>	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
-------------------------	----------------------------------	---	--------------------------------------	--	--------------------------------	--------------------------------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <b>Fredricktown, Mo.</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
---	-----------------------------------	--	---

13a. FATHER'S NAME <b>A.B. Hovis</b>	13b. MOTHER'S MAIDEN NAME <b>Lola Francis</b>	14. NAME OF HUSBAND OR WIFE <b>Troy Borders</b>
---	--	--

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>	16. SOCIAL SECURITY NO. <b>None</b>	17. INFORMANT <b>A.B. Hovis</b> Address <b>Bloomfield, Mo.</b>
--	--	---

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myo-cardial heart disease</b>		INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) _____	
	DUE TO (c) _____	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> <b>2</b>

20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
---	--

20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.	
---	--

20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION COUNTY STATE
--	--	--

21. I attended the deceased from <b>12-10-58</b> to <b>12-18-58</b> and last saw her alive on <b>12-18-58</b> Death occurred at <b>5:15 p.</b> m on the date stated above; and to the best of my knowledge, from the causes stated.
--

22a. SIGNATURE (Degree or title) <b>H.C. Wilson, M.D.</b>	22b. ADDRESS <b>Kennett, Mo.</b>	22c. DATE SIGNED <b>12/30/58</b>
--	-------------------------------------	-------------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>12-21-1958</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Memorial Park</b>	23d. LOCATION (City, town, or county) (State) <b>Malden, Missouri</b>
--	--------------------------------	--	--

24. FUNERAL DIRECTOR <b>Raymond L. Figgott</b> ADDRESS	25. DATE RECD. BY LOCAL REG. <b>12-31-1958</b>	26. REGISTRAR'S SIGNATURE <b>Paul Thurmond</b>
--	---	---

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

COUNTY FILE NUMBER 59-336

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 .....  
Signature of Student Embalmer

Signed *Lloyd Russell* .....

Licensed Embalmer No. 509-2

P. O. Address *Piggott, Ark*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.