

Health,  
Welfare  
Public  
Service

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-021221

FILED JUN 17 1959

Registration District No. 149 Primary Registration District No. 1002 STATE FILE NUMBER 2515 Registrar's No.

300  
1-57

1. PLACE OF DEATH a. COUNTY <b>Jackson</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Jackson</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Kansas City</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>Lees Summit</b> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>St. Mary's Hosp.</b>		Length of stay in hospital <b>2 wks.</b>	d. STREET ADDRESS (If outside, give location) <b>7000 Route # 2</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <b>GERALD</b> Middle <b>L.</b> Last <b>BORSERINE</b>			4. DATE OF DEATH Month <b>May</b> Day <b>21</b> Year <b>1959</b>			
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5. SEX <b>Male</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>1 Jan. 25, 1909</b>	9. AGE (In years birthday)	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) <b>Inspector</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Jackson Co. Engineering Co.</b>	11. BIRTHPLACE (City and state or country) <b>Kansas City, Ks.</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
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13a. FATHER'S NAME <b>Louis H. Borserine</b>	13b. MOTHER'S MAIDEN NAME <b>Mary B. Wagner</b>	14. NAME OF HUSBAND OR WIFE <b>Elizabeth</b>
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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>Ed. Borserine</b>	Address <b>K.C. Mo. 6420 Wenona</b>
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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>Generalized escurmatosis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>8 hrs.</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>Bronchogenic Ca.</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) <b>1621</b>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>

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.)
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20c. TIME OF INJURY Hour <input type="checkbox"/> a.m. <input type="checkbox"/> p.m.	20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE WORK <input type="checkbox"/> 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
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21. I attended the deceased from <b>July 58</b> to <b>21 May 59</b> and last saw <sup>her</sup> him alive on <b>20 May '59</b> Death occurred at _____ m on the date stated above; and to the best of my knowledge, from the <del>best</del> stated.		
22a. SIGNATURE <b>W W Gist</b> (Degree or title) <b>MD</b>	22b. ADDRESS <b>330 W 47</b>	22c. DATE SIGNED <b>21 May 59</b>

23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>May 23, 1959</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Olivet Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>Kansas City, Mo.</b>
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24. FUNERAL DIRECTOR <b>Mellody-McGilley-Eylar Funeral Home</b> <b>Woodland-Linwood</b>	25. DATE RECD. BY LOCAL REG. <b>5-21-59</b>	26. REGISTRAR'S SIGNATURE <b>Neva Minshall</b>
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USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

W. W. Gist

6981 2 I NDR

*J. W. W. Best*  
330 W 47 *Block*  
No 1-9676 *Bl*

*1-5 PM Thurs*

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 *J. W. W. Best* .....

Licensed Embalmer No. *2999* .....

P. O. Address *KC* .....

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.