

JURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-037303

FILED VS NOV 4 1959 311

STATE FILE NUMBER

Registration District No. _____ Primary Registration District No. 4456 Registrar's No. _____

UNRECORDED

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| 1. PLACE OF DEATH a. COUNTY <u>St Clair</u> b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Appleton City</u> Length of stay in 1b <u>2 1/2 Days</u> c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location) <u>Elliott Memorial Hospital</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>St. Clair</u> c. CITY OR TOWN <u>Appleton City</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> d. STREET ADDRESS (If outside, give location) <u>409 E 3RD ST.</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | |
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| 3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>Calvin</u> Last <u>Borum</u> | | | 4. DATE OF DEATH Month <u>Oct</u> - Day <u>28</u> - Year <u>1959</u> | | | | |
| 5. SEX <u>M</u> | 6. COLOR OR RACE <u>W</u> | 7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH <u>May-22-1873</u> | 9. AGE (last birthday) <u>86</u> | IF UNDER 1 YEAR: Months _____ Days _____ IF UNDER 24 HR: Hours _____ Min. _____ | | |
| 10a. USUAL OCCUPATION (Give kind of work done during past of working life, even if retired) <u>Carpenter</u> | | 10b. KIND OF BUSINESS OR INDUSTRY _____ | | 11. BIRTHPLACE (City and state or country) <u>Boone County Mo.</u> | | 12. CITIZEN OF WHAT COUNTRY <u>U. S. A</u> | |

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| 13a. FATHER'S NAME <u>Bushrod Borum</u> | | 13b. MOTHER'S MAIDEN NAME <u>unknown</u> | | 14. NAME OF HUSBAND OR WIFE <u>Nancy Borum</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u> | | 16. SOCIAL SECURITY NO. _____ | | 17. INFORMANT <u>Willard Borum, Appleton City</u> Address _____ | |

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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) <u>Carcinoma of Colon</u> Conditions, if any, which gave rise to above cause - (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ | | INTERVAL BETWEEN ONSET AND DEATH <u>6 years</u> |
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| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) _____ | | PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown | | |
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| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20a. ACCIDENT - SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <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 _____ a.m. _____ p.m. Month, Day, Year _____ | | 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 1953 to 28 Oct 59 and last saw him alive on 27 Oct 59
 Death occurred at 1:57 p.m. on the date stated above, and to the best of my knowledge, from the causes stated.

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| 22a. SIGNATURE <u>Willard Borum</u> (Degree, title) | 22b. ADDRESS <u>Appleton City</u> | 22c. DATE SIGNED <u>28 Oct 59</u> |
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| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 23b. DATE <u>Oct-30-1959</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Appleton City Cemetery</u> | 23d. LOCATION (City, town, or county) <u>Appleton City Mo.</u> |
| 24. FUNERAL DIRECTOR <u>Melvin L. Janssens, Appleton City</u> ADDRESS _____ | | 25. DATE RECD. BY LOCAL REG. <u>Oct. 29, 1959</u> | |
| 26. REGISTRAR'S SIGNATURE <u>Chas. Atney</u> | | | |

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

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 Melvin L. Janssens

Licensed Embalmer No. 4529

P. O. Address Appleton, Wis.

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.