

FEDERAL BUREAU OF INVESTIGATION - STANDARD CERTIFICATE OF DEATH
 FILED VS MAR 7 1960

60-002963
 STATE FILE NUMBER

2 2143

Registration District No. _____		Primary Registration District No. _____		Registrar's No. _____		
1. PLACE OF DEATH a. COUNTY _____			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY _____			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Louis</u>		Length of stay in 1b <u>18 days</u>	c. CITY OR TOWN <u>St. Louis</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Chronic Hospital</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>1474 Rowan</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Adelaide A/K/A Adaline</u> Middle _____ Last <u>Borg</u>			4. DATE OF DEATH Month <u>2</u> Day <u>22</u> Year <u>60</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <u>5/27/1880</u>	9. AGE (last birthday) <u>79</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>		11. BIRTHPLACE (City and state or country) <u>Illinois</u>	12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13a. FATHER'S NAME <u>Michael Borg</u>		13b. MOTHER'S MAIDEN NAME <u>Amelia Meyer</u>		14. NAME OF HUSBAND OR WIFE <u>None</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. <u>None</u>	17. INFORMANT Address <u>Emil Borg 1474 Rowan Ave.</u>			
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>Chronic Myocarditis</u>					INTERVAL BETWEEN ONSET AND DEATH <u>18 days.</u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Arteriosclerotic Heart Disease</u>					<u>18 days.</u>	
DUE TO (c) <u>Generalized Arteriosclerosis</u>					<u>18 days.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Terminal Bilateral Bronchiopneumonia</u>				PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" 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.) <u>420.0</u>			
20c. TIME OF INJURY Hour _____ a.m. _____ p.m. <u>2:35 P.M.</u>		Month, Day, Year <u>2/22/60</u>				
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.) <u>Chronic Hospital</u>		20f. CITY, TOWN, OR LOCATION <u>St. Louis</u>	COUNTY <u>Mo</u>	STATE <u>Mo</u>	
21. I attended the deceased from <u>Feb. 4, 1960</u> to <u>2/22/60</u> and last saw her/him alive on <u>2/22/60</u> Death occurred at <u>2:35 P.M.</u> on the date stated above, and to the best of my knowledge, from the causes stated.						
22a. SIGNATURE (Degree or title) <u>John W. Beckham, M.D.</u>			22b. ADDRESS <u>5800 E. Manual</u>		22c. DATE SIGNED <u>2/23/60</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>2-25-60</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Green Mount Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Belleville Ill.</u>		
24. FUNERAL DIRECTOR <u>J. Clark F.H. 1125 Hodiamont Ave.</u>		ADDRESS	25. DATE RECD. BY LOCAL REG. <u>FEB 24 1960</u>	26. REGISTRAR'S SIGNATURE <u>Carl Smith, M.D.</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 _____, Student Embalmer No. _____
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____

Signature of Student Embalmer

Signed _____

Alfred J. Boedeker

Licensed Embalmer No. 266

P. O. Address 11257

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to do so 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.