

**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

Do not use this space.

1. PLACE OF DEATH

County Jackson
Township Kaw
City Kansas City

Registration District No. 399
Primary Registration District No. 1002
(No. General Hospital)

File No. 29998
Registered No. 3835
St. _____ Ward _____

2. FULL NAME

Benjamin M. Borman
(a) Residence. No. 323 Grand Ave St. 1 Ward _____
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____

6. DATE OF BIRTH (MONTH, DAY AND YEAR) July 15 - 1979

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
51 2

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Railroad trainman
(b) General nature of industry, business, or establishment in which employed (or employer) _____
(c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN)

(STATE OR COUNTRY) Illinois

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY) England

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY) Illinois

14.

INFORMANT Isaac M. Borman

(Address) Chanute Kansas

15.

FILED 9/16 1930 M. M. Crowe

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Sept 15 1930

17. I HEREBY CERTIFY, That I attended deceased from Sept 7 1930 to Sept 15 1930 that I last saw him alive on Sept 15 1930, and that death occurred, on the date stated above, at 1:20 P. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

1 108 Typhoid fever
(duration) _____ yrs. _____ mos. 20 ds.

CONTRIBUTORY (SECONDARY)

Lobar pneumonia (duration) _____ yrs. _____ mos. 3 ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH Kansas City

DID AN OPERATION PRECEDE DEATH? No DATE OF _____

WAS THERE AN AUTOPSY? yes

WHAT TEST CONFIRMED DIAGNOSIS

(Signed) P. E. Williams, M. D.

9/16 1930 (Address) K. C. General Hosp. K.C. Mo.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) Whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL

Sanville Illinois DATE OF BURIAL Sept 17 1930

20. UNDERTAKER John J. Sheehan ADDRESS K. C. Mo.

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

RECORD RESERVED FOR INDEXING

V. S. No. 2.

