

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

MISSOURI STATE BOARD OF HEALTH
 STANDARD CERTIFICATE OF DEATH

State File No. 33578

Registration District No. 784

Primary Registration District No. 200

Registrar's No. 1794

1. PLACE OF DEATH:
 (a) County Saint Louis
 (b) City or town Jefferson Barracks, Mo.
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
Veterans Administration Facility
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution Adm: 9-21-39
 (Specify whether
 In this community Unkn.
 years, months or days)

2. USUAL RESIDENCE OF DECEASED:
 (a) State Illinois (b) County Washington
 (c) City or town Ashley
 (If outside city or town limits, write "RURAL")
 (d) Street No. _____
 (If rural, give location)
 (e) If foreign born, how long in U. S. A. ? _____ years.

3. (a) PRINT FULL NAME Walter Borowiak
3. (b) If veteran, name war World
3. (c) Social Security No. _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month October day 12
 year 1939 hour 9 minute 30 A. M.

4. Sex Male **5. Color or race** White
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Kaneth **6. (c) Age of husband or wife if alive** _____ years

21. I hereby certify that I attended the deceased from September 21, 1939, to October 12, 1939, that I last saw him alive on October 12, 1939, and that death occurred on the date and hour stated above.

7. Birth date of deceased May 13, 1894
 (Month) (Day) (Year)

Immediate cause of death Pulmonary tuberculosis, active, with pleural effusion.
 Duration Unkn.

8. AGE:	Years	Months	Days	If less than one day
	<u>45</u>	<u>4</u>	<u>29</u>	hr. _____ min.

Due to _____
 Due to _____

9. Birthplace Washington County Illinois
 (City, town, or county) (State or foreign country)

Other conditions Coronary sclerosis, Nephritis, chronic
 (Include pregnancy within 3 months of death)
 Unkn. PHYSICIAN

10. Usual occupation Blacksmith

Major findings:
 Of operations No operation
 Of autopsy _____
 Underline the cause to which death should be charged statistically

MOTHER FATHER
11. Industry or business _____
12. Name Joe Borowiak
13. Birthplace Not known
 (City, town, or county) (State or foreign country)
14. Maiden name Agnes Smith
15. Birthplace Not known
 (City, town, or county) (State or foreign country)

16. (a) Informant's own signature Clinical Clerk
(b) Address VAF., Jefferson Bks., Mo.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____

17. (a) Removal (b) Date thereof Oct 12, 1939
 (Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Radom, Illinois

(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

18. (a) Signature of funeral director Albert H. Honne Inc.
(b) Address 4700 Washington Blvd.

23. Signer C. W. HUGHES, Chief Med. Off. (M. D. or other)
Address VAF Jeff. Bks., Mo. **Date signed** 10-12-39

19. (a) OCT 12 1939 (b) _____
 (Date received local health officer) (Registrar's signature)

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 _____

_____, Registered Apprentice No. _____

working under my personal supervision.

Signed _____

Licensed Embalmer No. _____

P. O. Address _____

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank: