S. No. 2
—11-10-39
7. 5-17-39
I X21492

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

FILED JAN 8 1941

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 41318

Registration District No. 399 Primary Registration District No. 1002 Registrar's No. 4711

1. PLACE OF DEATH:

(a) County Jackson

(b) City or town Kansas City (If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution St Luke Hosp. 1 (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 8 days (Specify whether

In this community 8 days years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Jackson

(c) City or town Lees Summit (If outside city or town limits, write "RURAL")

(d) Street No. 6th & Green St. (If rural, give location)

(e) If foreign born, how long in U. S. A.? ..... years.

3. (a) PRINT FULL NAME Mary Kathryn Borgman

3. (b) If veteran, name war no

3. (c) Social Security No. no

4. Sex F

5. Color or race W

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Gilbert Borgman

6. (c) Age of husband or wife if alive 30 years

7. Birth date of deceased Feb (Month) 15 (Day) 1916 (Year)

8. AGE: Years 24 Months 9 Days 24 If less than one day ..... hr. ..... min.

9. Birthplace Lees Summit (City, town, or county) Mo (State or foreign country) 0

10. Usual occupation House Wife 0

11. Industry or business Home 0

FATHER
12. Name August L Tives
13. Birthplace Lees Summit (City, town, or county) Mo (State or foreign country)

MOTHER
14. Maiden name Lita Malicoat
15. Birthplace Roscoe (City, town, or county) Mo (State or foreign country)

16. (a) Informant Mrs August Tives

(b) Address Lees Summit Mo

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-11-40 (Month) (Day) (Year)

(c) Place: burial or cremation Lees Summit Mo

18. (a) Signature of funeral director N. B. Langsford

(b) Address Lees Summit Mo

19. (a) 12-11-40 (Date received local registrar) (b) M. M. Crowe (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 12 day 9 year 1940 hour ..... minute ..... M.

21. I hereby certify that I attended the deceased from ..... 19..., 19.....; that I last saw b..... alive on ..... 19.....; and that death occurred on the date and hour stated above.

Immediate cause of death

Due to Septic Abortion

Due to General Peritonitis

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations

Of autopsy Yes Nor Abortion

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify)

(b) Date of occurrence

(c) Where did injury occur? Unknown (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)

While at work? (e) Means of injury

23. Signature [illegible] (M. D. or other)

Address [illegible] Date signed 12/9/40

(Licensed Embalmer's Statement on Reverse Side)

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 with the above constitutes grounds for revocation of license.)

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

S. No. 2B
—2-21-40
I X22659

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 41318

Registration District No. 399 Primary Registration District No. 1002 Registrar's No. 4711

SUPPLEMENTARY

1. PLACE OF DEATH:

(a) County.....

(b) City or town..... (If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:

..... (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution..... (Specify whether years, months or days)

In this community.....

2. USUAL RESIDENCE OF DECEASED:

(a) State..... (b) County.....

(c) City or town..... (If outside city or town limits write "RURAL")

(d) Street No. 4 (If rural, give location)

(e) If foreign born, how long in U. S. A.?.....years.

3. (a) PRINT FULL NAME Mary Kathryn Bergman

3. (b) If veteran, name war..... 3. (c) Social Security No.....

4. Sex F | 5. Color or race..... | 6. (a) Single, widowed, married, divorced.....

6. (b) Name of husband or wife..... 6. (c) Age of husband, or wife, if alive.....years

7. Birth date of deceased..... (Month) (Day) (Year)

8. AGE: Years 24 | Months | Days | If less than one day ....hr. ....min.

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

10. Usual occupation.....

11. Industry or business.....

FATHER 12. Name.....

13. Birthplace..... (City, town, or county) (State or foreign country)

MOTHER 14. Maiden name.....

15. Birthplace..... (City, town, or county) (State or foreign country)

16. (a) Informant.....

(b) Address.....

17. (a) ..... (Burial, cremation, or removal) (b) Date thereof..... (Month) (Day) (Year)

(c) Place: burial or cremation.....

18. (a) Signature of funeral director.....

(b) Address.....

19. (a) 12/11/40 (Date received by local registrar) (b) M. M. Crowe (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 9 year 1940 hour..... minute.....M.

21. I hereby certify that I attended the deceased from....., 19....., to....., 19.....; that I last saw h..... alive on....., 19.....; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Septic Abortion	
Due to General Peritonitis	
Due to Criminal Abortion	
Other conditions (Include pregnancy within 3 months of death) 14 D	

Major findings:
Of operations.....

Of autopsy.....

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify).....

(b) Date of occurrence.....

(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?

While at work?..... (Specify type of place) (e) Means of injury.....

23. Signature..... (M. D. or other).....

Address..... Date signed.....

S-41318 1940