

No. 17-39
X21492

Registration District No. 821

Primary Registration District No. 6-572-4588

Registrar's No.

1. PLACE OF DEATH:

(a) County Scott
(b) City or town Sikeston
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Sikeston Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution About 1 day
(Specify whether
In this community
years, months or days)

3. (a) PRINT FULL NAME Dan J. Borders

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

4. Sex Male 5. Color or race white 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Rose Borders 6. (c) Age of husband or wife if alive 63 years

7. Birth date of deceased March 7-1867
(Month) (Day) (Year)

8. AGE: Years 74 Months 4 Days 22 If less than one day hr. min.

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

10. Usual occupation

11. Industry or business

12. Name David G. Borders

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

14. Maiden name Sophia Virginia

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

16. (a) Informant Roscoe Borders

(b) Address Sikeston Mo

17. (a) Burial (b) Date thereof Aug 2-4
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Memorial

18. (a) Signature of funeral director Watkins
(b) Address Harvey Mo

19. (a) 8-7-41 (b) W. H. Russell
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Scott
(c) City or town Sikeston
(If outside city or town limits, write "RURAL")
(d) Street No. D
(If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 31
year 1941 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from July 30, 1941, to July 31, 1941;
that I last saw him alive on July 31, 1941,
and that death occurred on the date and hour stated above.

Immediate cause of death: Shock
fracture Dislocation
of shoulder
possible internal
Due to _____
Due to _____

Other conditions: Chronic nephritis
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____
Of autopsy _____

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence July 31 1941
(c) Where did injury occur Sikeston Mo
(City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work? no (Specify type of place) (e) Means of injury Car wreck
23. Signature Howard M. ... (M. D.)
Address Sikeston Mo Date 8/3/41

Duration

1 day

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

H. M. Kendig.
Bawman-Wright
1 P.M.

D. J. Borders

H. M. Kendig

RECEIVED
District Health Office No 2,
District File Number 941-1232
Date Filed 9/8/41

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 B. J. Brentlinger
Licensed Embalmer No. 4261
P. O. Address Dexter, Mo.

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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 29541

Registration District No. 821

Primary Registration District No. 4588

Registrar's No.

1. PLACE OF DEATH:

(a) County Scott
(b) City or town Sikeston
(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.
In this community years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State (b) County
(c) City or town
(If outside city or town limits, write "RURAL")
(d) Street No.
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Dan J. Borders
3. (b) If veteran name war 3. (c) Social Security No.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July 1941 year 9 hour 35 minute M.
21. I hereby certify that I attended the deceased from
that I last saw him alive on
and that death occurred on the date and hour stated above.
Immediate cause of death

4. Sex m 5. Color or race w 6. (a) Single, widowed, married, divorced m
6. (b) Name of husband or wife 6. (c) Age of husband or wife if alive years
7. Birth date of deceased mar 7, 1867 (Month) (Day) (Year)

Due to Fracture Distraction of Lt shoulder - possible internal
Due to

8. AGE: Years 74 Months 4 Days 14 (If less than one day) min.

Other conditions (Include pregnancy within 3 months of death)
Major findings: Of operations 1700
Of autopsy 22
PHYSICIAN Underline the cause to which death should be charged statistically.

9. Birthplace (City, town, or county) (State or foreign country)
10. Usual occupation
11. Industry of business
12. Name
13. Birthplace (City, town, or county) (State or foreign country)
14. Maiden name (State or foreign country)
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) (Date received local registrar) (b) (Registrar's signature)

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? State Highway (City or town) (County) (State)
(d) In (a) injury on or about home, on farm, in industrial place, in public place?
Callahan with another
While at work? (Specify type of place) (c) Means of injury
23. Signature Howard M. Brady (M. D. or other)
Address Date signed

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

MOTHER FATHER

SUPPLEMENTARY

