

FILED APR 10 1944

State File No.

Registration District No. 128

Primary Registration District No. 2000

Registrar's No. 291

1. PLACE OF DEATH:

(a) County Greene
 (b) City or town Springfield
(If outside city or town limits, write "RURAL," and name of township)
 (c) Name of hospital or institution 1927 N. Benton
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 4 Months
(Specify whether years, months or days)
 In this community 4 Months
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Greene **39**
 (c) City or town Springfield **2**
(If outside city or town limits, write "RURAL")
 (d) Street No. 1927 N. Benton **6**
(If rural, give location)
 (e) Citizen of foreign country? 0 (Yes or No)
 If yes, name country 0

3. (a) PRINT FULL NAME Henry H. Bornhage

3. (b) If veteran, name war No 3. (c) Social Security 495-07-7795

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married
 6. (b) Name of husband or wife Maggie F. Bornhage 6. (c) Age of husband or wife if alive 26 years 1886
 7. Birth date of deceased Oct. 26
(Month) (Day) (Year)

8. AGE: Years 57 Months 5 Days 5 If less than one day hr. min.

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

10. Usual occupation Furniture Salesman

11. Industry or business

MOTHER FATHER { 12. Name Herman H. Bornhage
 13. Birthplace unk. Germany **4**
(City, town, or county) (State or foreign country)
 14. Maiden name Unknown
 15. Birthplace unk. Germany **4**
(City, town, or county) (State or foreign country)

16. (a) Informant Maggie F. Bornhage
 (b) Address Springfield, Mo.

17. (a) Burial (b) Date thereof April 4, 1944
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Greenlawn
 18. (a) Signature of funeral director H.H. Lohnmeyer
 (b) Address Springfield, Mo.

19. (a) 4-3-44 (b) BY W.S. Handley
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 31
 year 1944 hour 10 minute 30 **P.M.**

21. I hereby certify that I attended the deceased from Dec 10 1943 to MARCH 31 1944
 that I last saw him alive on MAR. 29 1944
 and that death occurred on the date and hour stated above.

Immediate cause of death HEART FAILURE **✓** Duration
Aortic Aneurism

Due to ✓

Other conditions.....
(Include pregnancy within 3 months of death)

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 AT Home (Specify type of place) (e) Means of injury 0
 23. Signature Dr. Thomas (M. D. or other)
 Address 324 Sanders Bldg Date signed 4/1/44

485

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

Walter E. Hamilton

Licensed Embalmer No.

3508

P. O. Address

Highspeed 176

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, fact should be so stated above.

Registration District No. 128 Primary Registration District No. 2000

1. PLACE OF DEATH:
(a) County Shelby
(b) City or town Springfield
(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 _____)
In this community _____ (Specify whether _____)
years, months or days

3. (a) PRINT FULL NAME Henry H. Bombage
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

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 Oct 26 (Month) (Day) (Year)

8. AGE: Years 57 Months 5 Days _____ (Unless than one day) min.

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

10. Usual occupation _____

11. Industry or business _____

12. Name _____

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

14. Maiden name _____

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

16. (a) Informant _____ (b) Address _____

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

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____ (b) Address _____

19. (a) _____ (b) _____ (Date received local registrar) (Registrar's signature)

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 _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month March Day 31 Year 1944 Hour _____ minute _____ M.
21. I hereby certify that I attended the deceased from _____, 19____; that I last saw him _____ alive on _____, 19____; and that death occurred on the date and hour stated above.

Immediate cause of death _____

Due to head failure

Due to aorta aneurysm

Due to Sepsis

Other conditions _____ (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 _____

(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 _____

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

SUPPLEMENTARY

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

MOTHER FATHER

10959