

FILED SEP 11 1947
 Registration District No. 297

Primary Registration District No. 3045

Registrar's No. 89

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

1. PLACE OF DEATH:
 (a) County Mississippi
 (b) City or town Charleston
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
304 Market St. Charleston, Mo.
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution.....
(Specify whether
 In this community 12 years
years, months or days)

2. USUAL RESIDENCE OF DECEASED:
 (a) State Missouri (b) County Mississippi
 (c) City or town Charleston Mo.
(If outside city or town limits, write "RURAL")
 (d) Street No. 304 Market St.
(If rural, give location)
 (e) Citizen of foreign country? No (Yes or No)
 If yes, name country.....

3. (a) PRINT FULL NAME SAMANTHIA ELLEN BORDERS

3. (b) If veteran, name war ✓
 3. (c) Social Security No. None

4. Sex Female 5. Color or race White
 6. (a) Single, widowed, married, divorced Married
 6. (b) Name of husband or wife Euphrates Borders 6. (c) Age of husband or wife if alive 75 years
 7. Birth date of deceased May 1 1877
(Month) (Day) (Year)

8. AGE: Years 70 Months 3 Days 22
 If less than one day hr. min.

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

10. Usual occupation Domestic

11. Industry or business

MOTHER FATHER
 12. Name John Jones
 13. Birthplace Allen Co. Ky
(City, town, or county) (State or foreign country)
 14. Maiden name Maria Taylor
 15. Birthplace Allen Co. Ky
(City, town, or county) (State or foreign country)

16. (a) Informant Euphrates Borders

(b) Address 304 Market St. Charleston, Mo.

17. (a) Burial (b) Date thereof Aug 24, 1947
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Gal Shove

18. (a) Signature of funeral director Thavis Shelby

(b) Address East Prairie Mo

19. (a) 9-4-47 (b) Mrs. John Borders
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month Aug day 23rd
 year 1947 hour 11 minute 07 A.M.
 21. I hereby certify that I attended the deceased for 8 yrs
 from 1947, 1947 to Aug 23 1947
 that I last saw her alive on Aug 22 1947
 and that death occurred on the date and hour stated above.

Immediate cause of death Uremia
 Duration

Due to Cerebral Vasc. Renal disease

Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings:
 Of operations none
 Of autopsy none 932
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) (c) Means of injury

Signature B. Charles Polwing (M. D. or other)

Address Charleston Mo. Date signed 8/25/47

RECEIVED

District Health Officer - No. 2,

District File Number 947-1196

Date Filed 9-9-47

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 Trevor Shelby

Licensed Embalmer No. 2726

P. O. Address East Prairie 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, fact should be so stated above.