

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-010722  
STATE FILE NUMBER  
Registrar's No. 3055

LED APR 10 1959 Registration District No. Primary Registration District No. Registrar's No. 3055

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY 7	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		c. CITY OR TOWN St. Louis	
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION 5811 Thekla Ave.		d. STREET ADDRESS (If outside, give location) 5811 Thekla Ave.	
3. NAME OF DECEASED (Type or print) First Middle Last Sara Catherine Borgers		4. DATE OF DEATH Month Day Year Mar. 26, 1959	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 28, 1885
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Seamstress		10b. KIND OF BUSINESS OR INDUSTRY Mutual Gar. Co.	11. BIRTHPLACE (City and state or country) Altenburg, Mo.
13a. FATHER'S NAME William Mueller		13b. MOTHER'S MAIDEN NAME Louise Hartung	14. NAME OF HUSBAND OR WIFE Bernard Borgers
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no none		16. SOCIAL SECURITY NO. 492-03-8866	17. INFORMANT Lucille Brase 5811 Thekla Ave.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ACUTE CORONARY INFARCT.</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <u>ARTERIO-SCLEROSIS.</u> DUE TO (c) <u>420.1</u>			INTERVAL BETWEEN ONSET AND DEATH <u>30 min.</u> <u>UNKNOWN.</u>
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.			
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION COUNTY STATE
21. I attended the deceased from <u>MARCH 16 1959</u> to <u>MCH 26 1959</u> and last saw her <u>live on MCH 26 1959</u> Death occurred at <u>6:45 AM</u> m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>E. C. Partridge</u> (Degree or title)		22b. ADDRESS <u>6673 Lillian St. Louis Mo</u>	22c. DATE SIGNED <u>3-26-59</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE March 28, 1959	23c. NAME OF CEMETERY OR CREMATORY Valley View Cemetery	23d. LOCATION (City, town, or county) (State) Edwardsville, Ill.
24. FUNERAL DIRECTOR JOHN STYGAR & SON 5541 Riverview Blvd.		25. DATE RECD. BY LOCAL REG. MAR 26 '59	26. REGISTRAR'S SIGNATURE <u>Earl Smith. M.D.</u> <u>acm.</u>

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

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 ....., Student Embalmer No. .... working under my personal supervision.

Student .....  
Signature of Student Embalmer

Signed *J.M. Fister* .....

Licensed Embalmer No. *3980* .....

P. O. Address *Sioux Falls, SD* .....

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.