

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

63-034300

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 317 Primary Registration District No. 500 Registrar's No. 2558 STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

FILED AUG 23 1963

1. PLACE OF DEATH a. COUNTY <u>ST LOUIS</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>AFTON</u>		c. CITY OR TOWN <u>ST. LOUIS</u>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>HENNINGER Nursing Home</u>		d. STREET ADDRESS (If outside, give location) <u>4114 NEBRASKA</u>	

3. NAME OF DECEASED (Type or print) First <u>JOSEPHINE</u> Middle <u>BORNE</u> Last <u>MAN</u>			4. DATE OF DEATH Month <u>August</u> Day <u>10</u> Year <u>1963</u>		
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>JUNE 14 1876</u>	9. AGE (last birthday) <u>87</u>	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MAINTAINANCE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OFFICE BLDGS.</u>		11. BIRTHPLACE (City and state or country) <u>CZECH SLOVAKIA</u>		12. CITIZEN OF WHAT COUNTRY <u>U-S-A</u>	
13a. FATHER'S NAME <u>UNKNOWN</u>			13b. MOTHER'S MAIDEN NAME <u>JOSEPHINE ODEHNAL</u>			14. NAME OF HUSBAND OR WIFE <u>FRED BORNEMAN (DEC)</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>				16. SOCIAL SECURITY NO. <u> </u>		17. INFORMANT <u>BLANCHE DUORAK 4632 N. Main</u>	

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>Arterio-sclerotic cardio-vascular disease</u>		INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>with auricular fibrillation and decompensated</u> DUE TO (c) <u>1000 3 yrs</u>		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Right broncho-pneumonia</u>		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown	
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19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	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 <u> </u> a.m. / p.m. Month, Day, Year		20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE 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 _____ to _____ and last saw her ^{him} alive on 10 Aug. 1963
Death occurred at 930 P on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <u>Robert S. Nye, M.D.</u>		22b. ADDRESS <u>3201 Arsenal St. St. Louis Mo</u>		22c. DATE SIGNED <u>12 Aug 1963</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL Aug 13, 1963</u>		23b. DATE <u> </u>		23c. NAME OF CEMETERY OR CREMATORY <u>St. MATTHEWS</u>	
23d. LOCATION (City, town, or county) <u>St Louis</u>		23e. DATE RECD. BY LOCAL REG. <u>8-13-63</u>		23f. REGISTRAR'S SIGNATURE <u>John H. Murphy</u>	
24. FUNERAL DIRECTOR <u>Thomas Rutis 2906 Gravois</u>		25. ADDRESS <u> </u>		26. REGISTRAR'S SIGNATURE <u> </u>	

(Licensed Embalmer's Statement on Reverse Side)

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
 ITEM NO. SHOULD READ INSTEAD OF DOCUMENT
 1 4000
 2 3159
 3
 4 1
 5 2
 6
 7 2
 8 2
 9 94331
 10
 11
 12 86-0
 13
 86
 USE BLACK INK OR TYPEWRITER RIBBON

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. G. Hornsby

Licensed Embalmer No. 4772

P. O. Address 2906 Travis

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.

12-3
DR. Robert T. ...
patient