S. No. 2
M—8-43
5-17-39
P I X37823

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED DEC 7 1944

Registration District No. 5

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 3009

State File No. 37377

Registrar's No. 28

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

6
2
1

1. PLACE OF DEATH:
(a) County Cape Girardeau
(b) City or town Jackson Mo
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Greens Ferry Road,
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution
(Specify whether years, months or days)
In this community

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Cape Girardeau
(c) City or town Jackson Mo
(If outside city or town limits, write "RURAL")
(d) Street No. Greens Ferry Road,
(If rural, give location)
(e) Citizen of foreign country? No, (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Amealia Borgfield,
3. (b) If veteran, name war
3. (c) Social Security No.

4. Sex F
5. Color or race W
6. (a) Single, widowed, married, divorced Widowed
6. (b) Name of husband or wife Henry Borgfield,
6. (c) Age of husband or wife if alive years
7. Birth date of deceased Sept 16 1857
(Month) (Day) (Year)

8. AGE: Years 87 Months 3 Days 15
If less than one day hr. min.

9. Birthplace Jackson Mo
(City, town, or county) (State or foreign country)
10. Usual occupation House work
11. Industry or business
FATHER
12. Name Welle
13. Birthplace Not Known
(City, town, or county) (State or foreign country)
MOTHER
14. Maiden name Not Known
15. Birthplace
(City, town, or county) (State or foreign country)
16. (a) Informant Hy Borgfield
(b) Address Jackson Mo
17. (a) Burial
(Burial, cremation, or removal)
(b) Date thereof 12/3/44
(Month) (Day) (Year)
(c) Place: burial or cremation Russell Hieghts
18. (a) Signature of funeral director McCombs Hill Co,
(b) Address Jackson Mo
19. (a) 12/3-1944
(Date received local registrar)
(b) J H Reisner
(Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec 1 day first year hour 12 minute 30 a.M.

21. I hereby certify that I attended the deceased from Nov 30, 1944, to Dec 1, 1944
that I last saw her alive on Nov 30, 1944
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Cerebral Hemorrhage	30 min
Due to Hypertension	5 yrs
Due to arterial sclerosis	20 yrs
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?
(Specify type of place)
While at work? (e) Means of injury

23. Signature T. E. Ruff (M. D. or other) MD
Address Jackson Mo Date signed Dec 2 1944

1116 (Licensed Embalmer's Statement on Reverse Side)

DEC 18 1944

RECEIVED
District Health Officer No. 4
District File Number 1244-4604
Date Filed 12-6-44

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 A Meyer

Licensed Embalmer No. 305-1

P. O. Address Jackson 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.