

**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

Do not use this space.

13361

1. PLACE OF DEATH

County..... Registration District No. **791**
 Townships..... Primary Registration District No. **1003** File No.....
 City St. Louis (No. Mullanphy Hospital) Registered No. 13682
 St. 3682 (Ward)

2. FULL NAME

Wm. Bonfile
 (a) Residence, No. 620 Graham St., 4 Ward.
 (Usual place of abode) (If nonresident give city or town and State)
 Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)

Male White Single

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR) April 17 1902

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
	<u>24</u>	<u>7</u>	<u>28</u>	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Labor
 (b) General nature of industry, business, or establishment in which employed (or employer) General Motor
 (c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) Bonfile
 (STATE OR COUNTRY) Mo.

10. NAME OF FATHER Frank Bonfile

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Mo.
 (STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER Elizabeth Bergfield

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Mo.
 (STATE OR COUNTRY)

14. INFORMANT Frank Bonfile
 (Address) St. Vincent Institution

15. FILED May 6 1927 Starke
 Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) April 15 1927

17. I HEREBY CERTIFY, That I attended deceased from 3/15, 1927, to 4-15, 1927
 that I last saw h. l. alive on 4-3 and that death occurred, on the date stated above, at 10:27 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Hypertension

(duration) yrs. 8 mos. da.

CONTRIBUTORY (SECONDARY) Cerebral Decrement
 (duration) yrs. mos. da.

18. WHERE WAS DISEASE CONTRACTED Mo.
 IF NOT AT PLACE OF DEATH

19. DID AN OPERATION PRECEDE DEATH? No DATE OF

20. WAS THERE AN AUTOPSY? Yes

WHAT TEST CONFIRMED DIAGNOSIS? (Signed) Charles Gunnison M.D.

(Address) Wm. Theatre Bldg

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL St. Ferdinand DATE OF BURIAL 4/18 1927

20. UNDERTAKER C. Helen Kelly ADDRESS 4624

London

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

THIS IS A PERMANENT RECORD

