

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.

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

Do not use this space.

41372

1. PLACE OF DEATH

County Jackson Registration District No. 399 File No. 3050  
Township West Primary Registration District No. 1002 Registered No. 5050  
City Kansas City (No. Kansas City General Hospital) Ward)

2. FULL NAME Bonnie Burns

(a) Residence, No. 2619 Prospect St., 11 Ward. (If nonresident, give city or town and State)  
(Usual place of abode)

Length of residence in city or town where death occurred 37 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

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

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 2-23-1905

7. AGE YEARS 32 MONTHS 8 DAYS 26 If LESS than 1 day, hrs. or min.

OCCUPATION 8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Fern Laundry  
9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.  
10. Date deceased last worked at this occupation (month and year)  
11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Marietta

MOTHER FATHER 13. NAME Warren Hill

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Indiana

15. MAIDEN NAME Anna Barker

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Marietta

17. INFORMANT (ADDRESS) Recent Clerk

18. BURIAL, CREMATION, OR REMOVAL PLACE Green Lawn DATE 11/22/36

19. UNDERTAKER (ADDRESS) Exlor Funeral Home

20. FILED Nov 20 1936 M. M. Crowe Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 11-19-1936

22. I HEREBY CERTIFY, That I attended deceased from 11-16-1936, to 11-19-1936

I last saw her alive on 11-19-1936 Death is said to have occurred on the date stated above, at 2:30 P.M.

The principal cause of death and related causes of importance were as follows:

Postoperative Sepsis  
Tuberc  
Postoperative Shock

Other contributory causes of importance:

Name of operation Excision of breast Date of 11-18-36

What test confirmed diagnosis Microscopic Was there an autopsy? yes

23. If death was due to external causes (violence), fill in also the following: Accident, suicide, or homicide? Date of injury 11-19-36

Where did injury occur? (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased?

If so, specify Postoperative Sepsis

(Signed) Dr. De Maria M.D.

(Address) Gen. Hosp., M. D.

(Address) K. C., Mo.



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

Do not use this space.

**1. PLACE OF DEATH**

County..... Registration District No..... File No.....  
Township..... Ordinary Registration District No..... Registered No. 5052  
City..... (No. General Hospital St. .... Ward)

**2. FULL NAME**

Bonnie Burns  
(a) Residence, No. .... St. .... 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. ds.

**PERSONAL AND STATISTICAL PARTICULARS**

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

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

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

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min. 31

OCCUPATION 8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. ....  
9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. ....  
10. Date deceased last worked at this occupation (month and year) ..... 11. Total time (years) spent in this occupation .....

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) .....

FATHER 13. NAME .....

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) .....

MOTHER 15. MAIDEN NAME .....

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) .....

17. INFORMANT (ADDRESS) .....

18. BURIAL, CREMATION, OR REMOVAL

PLACE DATE 19.....

19. UNDERTAKER (ADDRESS) .....

20. FILED 11/26 1936 J. H. Crowe Registrar.

**MEDICAL CERTIFICATE OF DEATH**

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 11-19-36

22. I HEREBY CERTIFY, That I attended deceased from .....

....., 19....., to....., 19.....

I last saw him alive on....., 19..... Death is said

to have occurred on the date stated above, at.....m.

The principal cause of death and related causes of importance were as follows:

P. O. Spinal Fusion  
stroke  
fracture of spine  
fracture of spine  
Other contributory causes of importance: details of accident unknown

Date of onset

Name of operation..... Date of.....

What test confirmed diagnosis?..... Was there an autopsy?.....

23. If death was due to external causes (violence), fill in also the following:

Accident, suicide, or homicide..... Date of injury....., 19.....

Where did injury occur..... (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury.....

Nature of injury.....

24. Was disease or injury in any way related to occupation of deceased?.....

If so, specify.....

(Signed)....., M. D.

(Address).....

**SUPPLEMENT**

**100**

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.

S-41372

RECORDED