

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**

17181  
 Do not use this space.  
4715

REC'D JUN 12 1939

791  
1008

1. PLACE OF DEATH

(a) County..... Registration District No.....

(b) Township..... Primary Registration District No.....

(c) City St. Louis (d) Street No. Homer G. Phillips Hospital St. (If death occurred in Hospital or Institution, write its name instead of street and number)

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

2. PRINT FULL NAME 532 Eleanor Elaine Bonds

(a) Residence, No. 1606 Carr St. St. 25 (If nonresident, give city or town and State)

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX F 4. COLOR OR RACE Negro 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) 1-13-39

|              |          |          |  |
|--------------|----------|----------|--|
| 7. AGE YEARS | MONTHS   | DAYS     | If LESS than 1 day, .....hrs. or .....min. |
|              | <u>3</u> | <u>3</u> |  |

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.

9. Industry or business in which work was done, as 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) St. Louis, (STATE OR COUNTRY) Mo.

FATHER

13. NAME unknown

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

MOTHER

15. MAIDEN NAME Louise Bonds

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

17. INFORMANT (ADDRESS) As the Mary Sherard  
2601 N Whittier St.

18. BURIAL, CREMATION, OR REMOVAL PLACE CITY CEMETERY DATE 5-25-39

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Mrs Hamilton  
City Health Dept.

20. MAY 24 1939

**MEDICAL CERTIFICATE OF DEATH**

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 4-16-1939

22. I HEREBY CERTIFY, That I attended deceased from 1-13- 1939 to 4-16- 1939

I last saw her alive on 4-16- 1939 Death is said to have occurred on the date stated above, at 10:17 a. m.

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

**Pulmonary Tuberculosis**

Date of onset

Other contributory causes of importance:

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

What test confirmed diagnosis Clinical 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....., 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) Wm B Smith, M. D.  
(Address) 2601 N Whittier St.

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**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.....

Licensed Embalmer No.....

P. O. Address.....

**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, above space should be left blank.**