

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 24635  
Registrar's No. 757

Registration District No. 85

Primary Registration District No. 1001

I. PLACE OF DEATH:

(a) County Buchanan  
(b) City or town St. Joseph  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
Missouri Methodist Hosp.  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or ~~home~~ 25 hours  
(Specify whether  In this community years, months or days)

3. (a) PRINT FULL NAME Minnie Bonham 550  
3. (b) If veteran, name war   
3. (c) Social Security No None

4. Sex female 5. Color or race white 6. (a) Single, widowed, married, divorced Widow  
6. (b) Name of husband or wife Ray Bonham 6. (c) Age of husband or wife if alive 4 years  
7. Birth date of deceased August 9 1886  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
53 11 6 hr. min.

9. Birthplace Severance Kansas  
(City, town, or county) (State or foreign country)

10. Usual occupation Janitor

11. Industry or business Doniphan County Kansas Court House

MOTHER FATHER { 12. Name James Huss

13. Birthplace Severance, Kansas  
(City, town, or county) (State or foreign country)

14. Maiden name Isabelle Walters

15. Birthplace LaRue County Kentucky  
(City, town, or county) (State or foreign country)

16. (a) Informant Lumie Rowland  
(b) Address Severance Kansas

17. (a) Removal (b) Date thereof 7.15.1940  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Troy, Kansas

18. (a) Signature of funeral director E. L. Carr  
(b) Address Troy, Kansas

19. (a) July 15 1940 (b) [Signature]  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Kansas (b) County Doniphan  
(c) City or town Troy  
(If outside city or town limits write "RURAL")  
(d) Street No. \_\_\_\_\_ (If rural, give location)  
(e) If foreign born, how long in U. S. A. \_\_\_\_\_ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 15  
year 1940 hour 1.10 a. m. minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from July 13  
1940 to July 15, 1940:  
that I last saw him alive on July 14, 1940  
and that death occurred on the date and hour stated above.

Immediate cause of death \_\_\_\_\_  
Coronary occlusion  
Due to arterio-sclerosis of coronary artery  
Due to \_\_\_\_\_

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

Major findings: \_\_\_\_\_  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_

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?  
85 (Specify type of place) \_\_\_\_\_  
While at work? \_\_\_\_\_ (e) Means of injury \_\_\_\_\_

23. Signature [Signature] (M. D. or other) [Signature]  
Address 301 1/2 St. Joseph Date signed July 15 - 1940

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

**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. 3532

P. O. Address Troy Kansas

**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.**