

REC'D MAY 11 1941

State File No. \_\_\_\_\_

Registration District No. 318

Primary Registration District No. 2001

Registrar's No. 133

1. PLACE OF DEATH:

(a) County Greene  
 (b) City or town Springfield  
 (If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution Springfield Baptist Hosp  
 (If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution 10 years  
 (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Texas 107  
 (c) City or town Cabool  
 (If outside city or town limits, write "RURAL") 0  
 (d) Street No. \_\_\_\_\_ (If rural, give location) 1  
 (e) If foreign born, how long in U. S. A. \_\_\_\_\_ years.

8. (a) PRINT FULL NAME Louis A. Bonfanti

8. (b) If veteran, name war No 8. (c) Social Security No. None

4. Sex Male 5. Color or race White  
 6. (a) Single, widowed, married, divorced Divorced  
 6. (b) Name of husband or wife Unknown 6. (c) Age of husband or wife if alive Unknown years  
 7. Birth date of deceased Dec 5 1871  
 (Month) (Day) (Year)

8. AGE: Years 69 Months 2 Days 9 If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

9. Birthplace St Louis (City, town, or county) Mo (State or foreign country)

10. Usual occupation LABOR

11. Industry or business \_\_\_\_\_

MOTHER FATHER  
 { 12. Name Unknown  
 { 13. Birthplace Unknown (City, town, or county) Unknown (State or foreign country)  
 { 14. Maiden name Unknown  
 { 15. Birthplace Unknown (City, town, or county) Unknown (State or foreign country)

16. (a) Informant Taylor, Elvith  
 (b) Address Cabool, Mo

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 15 1941  
 (Month) (Day) (Year)  
 (c) Place: burial or cremation Cabool, Mo

18. (a) Signature of funeral director Elliot Funeral Home  
 (b) Address Cabool, Missouri

19. (a) 2-15-41 (Data received local registrar) (b) W. E. Hardley, MD (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb day 15 1941  
 year 41 hour 1 minute 25 A M

21. I hereby certify that I attended the deceased from Feb 1 to Feb 14 1941  
 and that death occurred on the date and hour stated above.

Immediate cause of death: Acute Retention of Urine Duration 2/1/41  
 Due to Uremia 2/13/41  
 Due to Structure of urethra  
 Other conditions: \_\_\_\_\_ (Include pregnancy within 3 months of death)

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

23. Signature Robert Glyn (M. D. or other) RM  
 Address Springfield Date signed 2/19/41

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

19  
2  
6

126 K

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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.**

X

FILL IN ANSWERS TO ALL SPACES  
CHECKED IN RED PENCIL.

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

6947  
Do not use this space.

1. PLACE OF DEATH  
 (a) County Greene Registration District No. 318  
 (b) Township Springfield Primary Registration District No. 2001 Registered No. 133  
 (c) City Springfield (d) Street No. \_\_\_\_\_  
 (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 Louis a Bonfanti  
 (a) Residence, No. \_\_\_\_\_ St.  (If nonresident, give city or town and State)  
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX m 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED Div  
 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.  
69 2 9  
 OCCUPATION  
 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) (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. FUNERAL DIRECTOR (ADDRESS) \_\_\_\_\_  
 20. FILED \_\_\_\_\_ 19 \_\_\_\_\_

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Feb 14 1941  
 22. I HEREBY CERTIFY, That I attended deceased from \_\_\_\_\_ to \_\_\_\_\_, 19\_\_\_\_.  
 I last saw h. \_\_\_\_\_ 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:  
acute retention of urine  
fracture of urethra  
traumatism of perineum  
urinary fistula etc  
 Other contributory causes of importance: \_\_\_\_\_  
 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) Robert Glynn, M. D.  
 (Address) Springfield

SUPPLEMENT

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD---REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.  
 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.

L. X12241

Robert Glynn (M.D.) Springfield Mo

