

No. 2
4-12-40
5-17-39
I X23159

DEPARTMENT OF COMMERCE MISSOURI STATE BOARD OF HEALTH
BUREAU OF THE CENSUS
STANDARD CERTIFICATE OF DEATH

State File No. **10063**
Registrar's No. **251**

APR 15 1948
Registration District No. **1001**

Primary Registration District No. **1001**

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

1. PLACE OF DEATH:
(a) County **BUCHANAN**
(b) City or town **ST. JOSEPH**
(c) Name of hospital or institution **STATE HOSPITAL No. 2**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **10 mo 26 day**
(Specify whether in this community **10 mo 26 day**
years, months or days)

3. (a) PRINT FULL NAME **JAMES BONNAR**

3. (b) If veteran, name war **ARMY. DATE UNKNOWN** 3. (c) Social Security No. **none**

4. Sex **M** 5. Color or race **W** 6. (a) Single, widowed, married, divorced **W?**

7. Birth date of deceased **May 8 1872**
(Month) (Day) (Year)

8. AGE: Years **68** Month: **9** Days **23**
If less than one day hr. min.

9. Birthplace **Canada?**
(City, town, or county) (State or foreign country)

10. Usual occupation **Painter**

11. Industry or business

12. Name **William Bonnar**

13. Birthplace **Canada**
(City, town, or county) (State or foreign country)

14. Maiden name **Rebecca Jane Christie**

15. Birthplace **Canada**
(City, town, or county) (State or foreign country)

16. (a) Informant **Ray Records**

(b) Address **State Hosp #2 St Joseph, Mo.**

17. (a) **Reburial** (b) Date thereof **3-2-41**
(Month) (Day) (Year)

(c) Place: burial or cremation **K.C. Mo.**

18. (a) Signature of funeral director **B.W. Newcorn**
(b) Address **1401 Brush Creek Blvd**

19. (a) **3/2/41** (b) **H.J. Hestrich**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State **Mo** (b) County **Jackson**
(c) City or town **Little Blue 48**
(If outside city or town limits, write "RURAL")
(d) Street No. **County Home**
(If rural, give location)
(e) If foreign born, how long in U. S. A. **?** years.

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **March** day **15**
year **1941** hour **4** minute **55 P.M.**

21. I hereby certify that I attended the deceased from **May 15 1940** to **Mar 1 1941**
that I last saw him alive on **March 1 1941**
and that death occurred on the date and hour stated above.

Immediate cause of death **Bronchopneumonia**
Duration **10 days**

Due to **107**

Other conditions **Psychosis & Cerebral Arteriosclerosis**
(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? _____

15 (Specify type of place) _____
While at work? (e) Means of injury _____

23. Signature **Weneth Thompson** (M. D. or _____) **1320**
Address **State Hosp #2 St Joseph Mo** Date signed **3-2-41**

710-59

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, fact should be so stated above.