

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

40725

State File No. _____

Registrar's No. 919

FILED JAN 11 1942

Registration District No. 310

Primary Registration District No. 2000

39
62

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

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 986 - N Florence
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether
In this community _____
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County Greene
(c) City or town Springfield
(If outside city or town limits, write "RURAL")
(d) Street No. 986 - N Florence
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME HATTIE BONNER

3. (b) If veteran, name war None 3. (c) Social Security No. none

4. Sex 7 5. Color or race 3 Negro 6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Clifford Bonner 6. (c) Age of husband or wife if alive 49 years
7. Birth date of deceased Feb - 24 - 1895
(Month) (Day) (Year)

8. AGE: Years 47 Months 9 Days 26 If less than one day hr. min.

9. Birthplace Texas Arkansas Texas
(City, town, or county) (State or foreign country)

10. Usual occupation Domestic

11. Industry or business

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

16. (a) Informant Clifford Bonner

(b) Address 986 - N Florence

17. (a) Burial (b) Date thereof 12-22-42
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Lincoln Memorial

18. (a) Signature of funeral director H. Y. Smith

(b) Address 702 - N Jefferson

19. (a) 12-22-42 (b) H. Y. Smith
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 12 day 20
year 42 hour 11 minute 4 M.

21. I hereby certify that I attended the deceased from 10-1-
1942, to 12-20- 1942;
that I last saw her alive on 12-20-42 1942;
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Hemorrhage Duration 16 Days

Due to _____
Due to _____

Other conditions Diabetic Gangrene Nov 1st
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____
Of autopsy 61
PHYSICIAN _____
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?

(Specify type of place)
While at work? _____ (e) Means of injury _____
23. Signature R. E. Jenkins (M. D. or other) M.D.
Address 305 - College St Date signed 12-21-42

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..... *Herbert V Smith*.....
Licensed Embalmer No..... *4286*.....
P. O. Address..... *702 7th Jefferson*.....

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.