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15884

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH
1003

State File No. _____

Registrar's No. **4662**

FILED JUN 4 1943 318

Registration District No. _____

Primary Registration District No. _____

1. PLACE OF DEATH:

(a) County _____
(b) City or town **St. Louis, Missouri**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
St. Louis City Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **5 Days**
(Specify whether _____)
In this community _____
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo.** (b) County _____
(c) City or town **St. Louis**
(If outside city or town limits, write "RURAL")
(d) Street No. **5067 Cates Ave.,**
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

600
127
9

3. (a) PRINT FULL NAME **Sadie Bonner**

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

4. Sex **Female** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **Widowed**

6. (b) Name of husband or wife **Wm. H. Bonner** 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased **July 22, 1875.**
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
67 9 26 hr. min.

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

10. Usual occupation **Retired**

11. Industry or business _____

12. Name **Elias Cantrell**

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

14. Maiden name **Sarah Madden**

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

16. (a) Informant **Wm. H. Bonner Jr.**

(b) Address **5067 Cates Ave.,**

17. (a) **Burial** (b) Date thereof **May 20/43.**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Memorial Park Cem.,**

18. (a) Signature of funeral director **Jos. W. Clark**

(b) Address **1125 Hodiamont Ave.,**
MAY 19 1943 **J. F. Brisch**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **May** day **17.**
year **1943** hour **7:20** minute **P.** M.

21. I hereby certify that I attended the deceased from **May 13,** 1943, to **May 17,** 1943
that I last saw him **ER** alive on **May 17,** 1943
and that death occurred on the date and hour stated above.

Immediate cause of death **Carcinoma of bladder**
Uprinary

Due to _____
Due to **520**

Other conditions **Unilateral edema**
(Include pregnancy within 3 months of death) **Obesity**

Major findings: Of operations _____

Of autopsy **Carcinoma of bladder**
Hydrocephalus, bilateral.

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? _____

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

23. Signature **Grady U. Fleber** (M. D. or other) **M.D.**
Address **1115 Lafayette Avenue,** Date signed **5/17/43**

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

MOTHER FATHER

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.....

Allen J. Kelly
Licensed Embalmer No. **3225**

P. O. Address..... **1125 Hodiament Ave.,**

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.