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State File No. 25602
Registrar's No. 18

FILED JUL 30 1948 37

Registration District No. 37

Primary Registration District No. 4353

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

1. PLACE OF DEATH:

(a) County New Madrid
 (b) City or town Hibson
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: 1
 (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) (Specify whether

3. (a) PRINT FULL NAME BONNIE SUE WILSON
 3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex Female 5. Color or race W
 6. (a) Single, widowed, married, divorced _____
 6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if
 alive _____ years
 7. Birth date of deceased: March 14 1943
 (Month) (Ddy) (Year)

8. AGE: Years Months Days If less than one day
3 14 hr. min.

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

10. Usual occupation _____

11. Industry or business _____

12. Name Bonnie Boone

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

14. Maiden name Mae Smithson

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

16. (a) Informant Bonnie Boone

(b) Address Hibson, Mo.

17. (a) Burial (b) Date thereof 6-29-43
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation North Cagon

18. (a) Signature of funeral director Lambert Funeral Home

(b) Address Campbell, Mo

19. (a) June 24/48 (b) _____
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County New Madrid
 (c) City or town Hibson
 (If outside city or town limits, write "RURAL")
 (d) Street No. _____ (If rural, give location)
 (e) Citizen of foreign country? _____ (Yes or No)
 If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 28
 year 1943 hour _____ minute 10.00 A.M.

21. I hereby certify that I attended the deceased from _____
 19 _____ to _____ 19 _____;
 that I last saw him _____ alive on _____ 19 _____;
 and that death occurred on the date and hour stated above.

Immediate cause of death Cholera

Due to _____

Due to _____

Other conditions: 119a
 (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?

While at work? _____ (Specify type of place) (Type of means of injury)

23. Signature [Signature] (M. D. or other) _____

Address _____ Date signed 6/28/43

Duration _____
 PHYSICIAN _____
 Underline the cause to which death should be charged statistically.

RECEIVED

District Health Office No. 2,

District File Number 742-959

Date Filed 7-23-43

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.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. Aug

Registration District No. 237

Primary Registration District No. 4253

Registrar's No. 18

1. PLACE OF DEATH:

(a) County New Madrid
(b) City or town Indian
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(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)

3. (a) PRINT FULL NAME Bonnie Sue Wilson

3. (b) If veteran, name war..... 3. (c) Social Security No.....

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

6. (b) Name of husband or wife..... 6. (c) Age of husband or wife if alive..... years

7. Birth date of deceased.....
(Month) (Day) (Year)

8. AGE: Years Months Days (If less than one day) min.

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

10. Usual occupation

11. Industry or business

12. Name

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

14. Maiden name (City, town, or county) (State or foreign country)

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

16. (a) Informant

(b) Address

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

(c) Place: burial or cremation.....

18. (a) Signature of funeral director

(b) Address

19. (a) (Date received local registrar) (b) Zelda Mason (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June Day 25 year 1943 hour 10 minute 25 M.

21. I hereby certify that I attended the deceased from..... 19.....
that I last saw him/her alive on..... 19.....
and that death occurred on the date and hour stated above.
Immediate cause of death.....

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

Due to.....

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?

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

23. Signature..... (M. D. or other).....

Address..... Date signed.....

WRITE FULLY-USE UNFADING BLACK INK-MAKE A PERMANENT RECORD

SUPPLEMENTARY

S-25602