

Registration District No. **194018**

Primary Registration District No. **1003**

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

1. PLACE OF DEATH:

(a) County **ST. LOUISIS**

(b) City or town **ST. LOUISIS**  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:  
**CITY HOSPITAL 0**  
(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 **CLARA ELIZABETH BOND**

3. (b) If veteran, name war \_\_\_\_\_

3. (c) Social Security No. \_\_\_\_\_

4. Sex **F**

5. Color or race **W**

6. (a) Single, widowed, married, divorced **WIDOWED**

6. (b) Name of husband or wife **HARRY M. BOND**

6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased **JAN. 18 1897**  
(Month) (Day) (Year)

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

**46 8 8** hr. min.

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

10. Usual occupation **FOLDER IN FLATWORK**

11. Industry or business **GLICKS LAUNDRY**

12. Name **JAMES BIXLER**

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

14. Maiden name **MARY BISHOP**

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

16. (a) Informant **Mary Bond**

(b) Address **3949th Washington**

17. (a) (Burial, or removal) \_\_\_\_\_ (b) Date thereof **19-29-43**  
(Month) (Day) (Year)

(c) Place: burial or cremation **MEMORIAL PARK**

18. (a) Signature of funeral director **L. M. Mullen**

(b) Address **5165 Delmar Bl**

19. (a) **SEP 28 1943** (Date received by Registrar) **J. F. Buech** (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED: **000**

(a) State **MO.** (b) County **17**

(c) City or town **ST. LOUISIS** **9**  
(If outside city or town limits, write "RURAL")

(d) Street No. **4028 WASHINGTON**  
(If rural, give location)

(e) Citizen of foreign country? **NO** (Yes or No)  
If yes, name country **0**

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Sept** day **26**  
year **1943** hour **11** minute **45** AM

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 **Acute peritonitis, self administered at her home Sept. 26 1943 about 1:15 PM**

Due to \_\_\_\_\_

Due to **1637**

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) **Suicide**

(b) Date of occurrence **Sept. 26 1943**

(c) Where did injury occur? **St. Louis**  
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?  
**1 home**

While at work? **no** (Specify type of place) (e) Means of injury **Person**

23. Signature **Dr. Alfred P. Perry** (M. D. or other)  
Address **Deputy Coroner** Date signed **9/28/43**

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

DEC 6 1944

FEB 1 1945

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 W. G. Farris  
Licensed Embalmer No. 3384  
P. O. Address St. Louis

**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.**