DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED FEB 16 1944

Registration District No. 301

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 6037

8134

State File No.

Registrar's No. 1944

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

1. PLACE OF DEATH:

(a) County: Ripley

(b) City or town: Doniphan Twp

(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: at home / Rural

(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution (Specify whether years, months or days)

In this community: life

2. USUAL RESIDENCE OF DECEASED:

(a) State: Mo (b) County: Ripley

(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): 0

If yes, name country:

3. (a) PRINT FULL NAME: Bonnie Mae Terry

3. (b) If veteran, name war:

3. (c) Social Security No.:

4. Sex: Female

5. Color or race: White

6. (a) Single, widowed, married, divorced: 0

6. (b) Name of husband or wife:

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

7. Birth date of deceased: Jan. (Month) 9 (Day) 1944 (Year)

8. AGE: Years —; Months —; Days 23; If less than one day: hr. min.

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

10. Usual occupation: Infant.

11. Industry or business:

FATHER

12. Name: Jake Terry

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

MOTHER

14. Maiden name: Dorothy Dudley.

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

16. (a) Informant: Jake Terry

(b) Address: Doniphan Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: 2-3-44 (Month) (Day) (Year)

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

18. (a) Signature of funeral director: H. E. Inman

(b) Address: Doniphan Mo.

19. (a) 2-14-44 (Date received local registrar) (b) E. B. Johnston (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb. day 1 year 1944 hour 11 minute P. M.

21. I hereby certify that I attended the deceased from 1-30 —, 1944, to 2-2 —, 1944; that I last saw her alive on 1-30 —, 1944; and that death occurred on the date and hour stated above.

Immediate cause of death: Bronchial Pneumonia

Due to: Influenza

Due to:

Other conditions (Include pregnancy within 3 months of death): 330

Major findings: Of operations:

Of autopsy:

Duration

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: 0

23. Signature: J. Edw. Adamson (M. D.)

Address: Doniphan, Mo. Date signed 2-2-44

674

(Licensed Embalmer's Statement on Reverse Side)

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. 3200

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.

No. 2B
1—5-43
I X38930

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

MAR

State File No. ____

Registration District No. 301 Primary Registration District No. 6037 Registrar's No. ____

1. PLACE OF DEATH:
(a) County Ripley
(b) City or town Doniphan (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 years, months or days)
In this community ____

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo (b) County Ripley
(c) City or town Rural (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 ____

3. (a) PRINT FULL NAME Bonnie Mae Terry
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 S
6. (b) Name of husband or wife ____
6. (c) Age of husband or wife if alive ____ years
7. Birth date of deceased Jan 9 1944 (Month) (Day) (Year)
8. AGE: Years ____ Months ____ Days ____ If less than one day ____ hr. ____ min.
9. Birthplace ____ (City, town, or county) Mo. (State or foreign country)
10. Usual occupation ____
11. Industry or business ____
FATHER 12. Name ____
13. Birthplace ____ (City, town, or county) ____ (State or foreign country)
MOTHER 14. Maiden name ____
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) ____ (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan Day ____ year 1944 hour ____ minute ____ M.
21. I hereby certify that I attended the deceased from ____, 19____, to ____, 19____; that I last saw h____ alive on ____, 19____; and that death occurred on the date and hour stated above.
Immediate cause of death ____ Duration
Due to ____
Due to ____
Other conditions (Include pregnancy within 3 months of death) ____
Major findings:
Of operations ____
Of autopsy ____

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 ____ (M. D. or other) ____
Address ____ Date signed ____

SUPPLEMENTARY

8134