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DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUSSTATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No.

27723

AUG 23 1944  
Registration District No. 128

Primary Registration District No. 5466

Registrar's No.

664

## 1. PLACE OF DEATH:

(a) County Greene  
 (b) City or town Rural, S Campbell Twp.  
 (If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution:  
Medical Center for Federal Prisoners 9  
 (If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution 4 days  
 (Specify whether years, months or days)  
 In this community 4 days

3. (a) PRINT FULL NAME BONDS, Isaac3. (b) If veteran, name war UNK. 3. (c) Social Security No. UNK.

4. Sex Male 5. Color or race Negro 6. (a) Single, widowed, married, divorced widowed  
 6. (b) Name of husband or wife Lola Harris 6. (c) Age of husband or wife if alive Doc. years  
 7. Birth date of deceased UNK. UNK. 1894  
 (Month) (Day) (Year)

8. AGE: Years 50 Months UNK. Days UNK. If less than one day  
 hr. min.

9. Birthplace Bassfield Mississippi  
(City, town, or county) (State or foreign country)10. Usual occupation Laborer

11. Industry or business

12. Name Frank Bonds  
 13. Birthplace UNK. Mississippi  
 (City, town, or county) (State or foreign country)  
 14. Maiden name UNK.  
 15. Birthplace UNK. UNK. 9  
 (City, town, or county) (State or foreign country)

16. (a) Informant File M.C.F.P.  
 (b) Address Springfield, Mo  
 17. (a) Removal (b) Date thereof Aug 16, 1944  
 (Burial, cremation, or removal) (Month) (Day) (Year)  
 (c) Place: burial or cremation Hattiesburg, Miss.  
 18. (a) Signature of funeral director Ered C. Piame  
 (b) Address 1100 Bonville St., Spfld., Mo.  
 19. (a) 8-16-44 (b) \_\_\_\_\_  
 (Date received local registrar) (Registrar's signature)

## 2. USUAL RESIDENCE OF DECEASED:

(a) State Mississippi (b) County Harrison  
 (c) City or town Gulfport  
 (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 August day 13  
 year 1944 hour 9 minute 40 AM.  
 21. I hereby certify that I attended the deceased from August  
9, 1944, to August 13, 1944;  
 that I last saw him alive on August 13, 1944;  
 and that death occurred on the date and hour stated above.  
 Immediate cause of death Cerebral hemorrhage

Due to \_\_\_\_\_  
 Due to \_\_\_\_\_  
 Other conditions Granuloma inguinale  
 (Include pregnancy within 3 months of death) Stricture of urethra  
Stricture of rectum  
 Major findings:  
 Of operations \_\_\_\_\_  
 Of autopsy \_\_\_\_\_  
 Approx 15 yrs  
 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 E.W. Moulford (M. D. SPFLD.)  
 Address Med. Centr. Federal Pris. Date signed 8-16-44

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

MOTHER FATHER

93114

**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 Fred. C. Thieme

Licensed Embalmer No. 2899

P. O. Address Springfield

**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.**

X

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. Sept.  
Registrar's No. 664

Registration District No. 128 Primary Registration District No. 5466

1. PLACE OF DEATH:  
(a) County Greene  
(b) City or town Rural Campbell  
(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 \_\_\_\_\_ (Specify whether \_\_\_\_\_)  
years, months or days

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 \_\_\_\_\_

3. (a) PRINT FULL NAME Isaac Bond  
(b) If veteran, name war \_\_\_\_\_ (c) Social Security No. \_\_\_\_\_

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month Aug Day 13  
Year 1944 Hour \_\_\_\_\_ minute \_\_\_\_\_ M.  
21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_;  
that I saw him \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_;  
and that death occurred on the date and hour stated above.  
Immediate cause of death \_\_\_\_\_ Duration \_\_\_\_\_

4. Sex m 5. Color or race B  
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: (Month) \_\_\_\_\_ (Day) \_\_\_\_\_ (Year) \_\_\_\_\_

8. AGE: Years 50 Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day \_\_\_\_\_ min.

9. Birthplace: (City, town, or county) Miss (State or foreign country) \_\_\_\_\_

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

MOTHER FATHER { 12. Name \_\_\_\_\_  
13. Birthplace: (City, town, or county) \_\_\_\_\_ (State or foreign country) \_\_\_\_\_  
14. Maiden name \_\_\_\_\_  
15. Birthplace: (City, town, or county) \_\_\_\_\_ (State or foreign country) \_\_\_\_\_

16. (a) Informant \_\_\_\_\_  
(b) Address \_\_\_\_\_

17. (a) \_\_\_\_\_ (b) Date thereof: (Month) \_\_\_\_\_ (Day) \_\_\_\_\_ (Year) \_\_\_\_\_  
(Burial, cremation, or removal) \_\_\_\_\_  
(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_  
(b) Address \_\_\_\_\_

19. (a) \_\_\_\_\_ (b) (Signature)  
(Date received local registrar) \_\_\_\_\_ (Registrar's signature) \_\_\_\_\_

Due to \_\_\_\_\_  
Due to \_\_\_\_\_  
Other conditions: \_\_\_\_\_ (Includes 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 PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

SUPPLEMENTARY

