

FILED OCT 11 1945

Registration District No. **107**

Primary Registration District No. **3-0195422**

Registrar's No. **15**

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

1. PLACE OF DEATH:

(a) County **De Witt**
(b) City or town **Kennett Rural 1**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: **Independence, Mo.**
(If not in hospital or institution, write street number or location) **/**
(d) Length of stay: In hospital or institution: **Eight months**
In this community: **Eight months**
years, months or days (Specify whether)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo** (b) County **De Witt**
(c) City or town **Kennett Rural 1**
(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 **Arnold Bonds**

3. (b) If veteran, name war _____ 3. (c) Social Security No. **431-09-2543**

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

6. (b) Name of husband or wife **Maggie Bonds** 6. (c) Age of husband or wife if alive **61** years

7. Birth date of deceased **Aug 17 1889**
(Month) (Day) (Year)

8. AGE: **56** Years **29** Months **29** Days If less than one day hr. _____ min.

9. Birthplace **Cross timber** **MO**
(City, town, or county) (State or foreign country)

10. Usual occupation **Farm Labor**

11. Industry or business _____

12. Name **J. D. Bonds**

13. Birthplace **Cross timber** **MO**
(City, town, or county) (State or foreign country)

14. Maiden name **Mary Shaffard**

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

16. (a) Informant **Effie Roberts**
(b) Address **Kennett R. 2**

17. (a) **Burial** (b) Date thereof **9-17-45**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **J. C. Kerman Ark.**

18. (a) Signature of funeral director **Frank Leach**
(b) Address **New Paris Ark.**
19. (a) **9-15-45** (b) **Carl Husband**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **September** day **fifteenth**
year **1945** hour **five** minute **15 P.** M.

21. I hereby certify that I attended the deceased from **fifteenth of May**, 19**45**, to **September 15, 1945**; that I last saw him alive on **August 27th**, 19**45**; and that death occurred on the date and hour stated above.

Immediate cause of death **Cerebral Thrombosis** Duration **2 hrs**

Due to **Cerebral Thrombosis** 1 or 2 yrs.

Due to _____

Other conditions (Include pregnancy within 3 months of death) _____

Major findings: Of operations **940**
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 **2**

23. Signature **Allen H. Christianney** (M.D. or other) **D.O.**
Address **Kennett, Missouri** Date signed **9-15-45**

PHYSICIAN

Underline the cause to which death should be charged statistically.

RECEIVED
District Health Office No. 2,
District File Number 1045-3103
Date Filed 10-8-45

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 *Walter A. Hawpeis*
Licensed Embalmer No. *2002*
P. O. Address *Kennett mo*

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.