

UNITED STATES DEPARTMENT OF HEALTH
STANDARD CERTIFICATE OF DEATH

Registration District No. 318 Primary Registration District No. 1003

1. PLACE OF DEATH:
(a) County
(b) City or town St Louis
(c) Name of hospital or institution: Homer G Phillips Hospital
(d) Length of stay: In hospital or institution 16 days
In this community 2 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo (b) County
(c) City or town St Louis
(d) Street No. 3742 Cozens
(e) Citizen of foreign country? no

3: (a) PRINT FULL NAME Annie Bonner
3. (b) If veteran, name war
3. (c) Social Security No.

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month September, day 1, year 1948 hour 12 minute 15 P. M.
21. I hereby certify that I attended the deceased from August 15, 1948, to September 1, 1948, that I last saw her alive on September 1, 1948, and that death occurred on the date and hour stated above.

4. Sex Female 5. Color or race Col.
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Nathan Bonner
6. (c) Age of husband or wife if alive 58 years
7. Birth date of deceased December 24 1900
8. AGE: Years Months Days If less than one day
47 8 7 hr. min.

Immediate cause of death
Degenerative Heart Disease
Prob Pulmonary Infarcts
Prob Bilateral Pleural Effusion
Due to
Other conditions
Major findings:
Of operations
Of autopsy

9. Birthplace Minden La.
10. Usual occupation Domestic
11. Industry or business
12. Name unknown
13. Birthplace unknown
14. Maiden name unknown
15. Birthplace unknown
16. (a) Informant Nathan Bonner
(b) Address 3742 Cozens Ave.
17. (a) Burial (b) Date thereof 9 - 7 - 48
(c) Place: burial or cremation Washington Park Cemetery
18. (a) Signature of funeral director Ellis Funeral Home
(b) Address 2820 Stoddard St.
19. (a) SEP 7 1948 (b) J. F. Medek

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?
(d) Did injury occur in or about home, on farm, in industrial place, in public place?
While at work? (Specify type of place) (c) Means of injury
23. Signature Dr. Daniels (M. D. certified)
Address 2601 N. Whittier Date signed 9-2-48

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

MOTHER FATHER

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. Claude Jordan
Licensed Embalmer No. 3489
P. O. Address 4575 Aldene

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.