

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

6936

State File No.

FILED FEB 25 1952

BIRTH NO. _____ REG. DIST. NO. 322 PRIMARY REG. DIST. NO. 3071 Registrar's No. 10

1. PLACE OF DEATH a. COUNTY Saline		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Mo. b. COUNTY Saline	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Slater	c. LENGTH OF STAY (in this place) 4 yrs	c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Slater	
d. FULL NAME OF HOSPITAL OR INSTITUTION none		d. STREET ADDRESS (If rural, give location) 221 Leroy St.	

3. NAME OF DECEASED (Type or Print) a. (First) Malvina b. (Middle) Wolford c. (Last) Bonar			4. DATE OF DEATH (Month) (Day) (Year) Feb. 16-1952		
5. SEX female	6. COLOR OR RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married	8. DATE OF BIRTH May 15th-1877	9. AGE (In years last birthday) 74	IF UNDER 1 YEAR Months 0 Days 1 Hours 1 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) at home		10b. KIND OF BUSINESS OR INDUSTRY housewife	11. BIRTHPLACE (State or foreign country) Nelson, Mo.		12. CITIZEN OF WHAT COUNTRY? U.S.

13a. FATHER'S NAME Jno. L. Wolford	13b. MOTHER'S MAIDEN NAME Mary Freeman	14. NAME OF HUSBAND OR WIFE Mrs. B. M. Bonar
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)	16. SOCIAL SECURITY NO. none	17. INFORMANT'S SIGNATURE OR NAME Mrs. Forest Bonar, ADDRESS Slater, Mo.
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.	1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral hemorrhage		INTERVAL BETWEEN ONSET AND DEATH 4 days
	ANTECEDENT CAUSES Left hemiplegia		
	II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Fractured Right Hip		14 wks.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify) <input checked="" type="checkbox"/>	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Home	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) Slater Saline Mo.
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) 11 4 51 m.	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	21f. HOW DID INJURY OCCUR? Fall getting out of bed
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22. I hereby certify that I attended the deceased from **Nov. 5, 1952** to **Feb. 16, 1952**, that I last saw the deceased alive on **Feb. 16, 1952**, and that death occurred at **7:00 A.M.**, from the causes and on the date stated above.

23a. SIGNATURE O. U. McBurney (Degree or title)	23b. ADDRESS Slater, Mo.	23c. DATE SIGNED 2/16/52
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24a. BURIAL CREMATION; REMOVAL (Specify) Burial	24b. DATE 2/18/52	24c. NAME OF CEMETERY OR CREMATORY City Cemetery	24d. LOCATION (City, town, or county) (State) Slater, Mo.
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DATE REC'D BY LOCAL REG. 2/19/52	REGISTRAR'S SIGNATURE Mrs. Earl C. [unclear]	25. FUNERAL DIRECTOR'S SIGNATURE Sill Brothers ADDRESS Slater, Mo.
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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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 _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed A. C. Hill

Licensed Embalmer No. 3090.

P. O. Address Staten, 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.