

FILED APR 30 1958

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-014799

STATE FILE NUMBER

Registration District No. 170 Primary Registration District No. 3033 Registrar's No. 70

S. 300
1-57
5320

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

1. PLACE OF DEATH a. COUNTY <u>Laclede</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>Laclede</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Lebanon</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>Lebanon</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> <u>0532</u>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Wallace Memo. Hosp.</u> Length of stay in 1b <u>50 yrs</u>		d. STREET ADDRESS (If outside, give location) <u>575 Bland Ave.</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED First Middle Last <u>Martha R Bonar</u>			4. DATE OF DEATH Month Day Year <u>April 23 1958</u>
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> <u>2</u>	8. DATE OF BIRTH <u>Aug. 4 1864</u>
9. AGE (In years last birthday) <u>93</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>At Home</u>	11. BIRTHPLACE (City and state or country) <u>Guernsey Co. Ohio</u>
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		13a. FATHER'S NAME <u>Wm. S. Baird</u>	13b. MOTHER'S MAIDEN NAME <u>Mary J. Adams</u>
14. NAME OF HUSBAND OR WIFE <u>Sam Bonar</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, or unknown) (If yes, give war or dates of service) <u>No</u>	16. SOCIAL SECURITY NO. <u>None</u>
17. INFORMANT Address <u>Miss. Olive Reed Lebanon Mo.</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Decompensation</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <u>Senility</u> DUE TO (c) <u>4344</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <u>12 hrs.</u>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> <u>2</u>		20a. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)		20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.	
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
20f. CITY, TOWN, OR LOCATION		COUNTY STATE	
21. I attended the deceased from <u>4-12-58</u> , to <u>4-23-58</u> and last saw her <u>live on 4-23-58</u> Death occurred at <u>1.00</u> P. m. on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>W. Cunningham M.D. for P. G. O. Lebanon, Mo.</u>		22b. ADDRESS <u>Lebanon, Mo.</u>	
22c. DATE SIGNED <u>4-25-58</u>		23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	
23b. DATE <u>4/26/58</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Lebanon City Cem.</u>	
23d. LOCATION (City, town, or county) (State) <u>Lebanon Mo.</u>		24. FUNERAL DIRECTOR ADDRESS <u>S. R. Bulmy Lebanon Mo</u>	
25. DATE RECD. BY LOCAL REG. <u>4-25-1958</u>		26. REGISTRAR'S SIGNATURE <u>Hella L. Hays</u>	

Received APR 28.1958
St. Louis Laclede County Health Unit
File No. 70
Date Filed APR 28 1958

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
Signature of Student Embalmer

Signed S. P. Palmer

Licensed Embalmer No. 2208

P. O. Address St. Louis, 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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.