MAY 27 1927

# MISSOURI STATE BOARD OF HEALTH
## BUREAU OF VITAL STATISTICS
### CERTIFICATE OF DEATH

Do not use this space.

11447

File No. .....

Registered No. 254

1. PLACE OF DEATH

County Greene — Registration District No. 318

Township ..... — Primary Registration District No. 2001

City Springfield, Mo. (No. 820 E. Delmont St. ..... Ward)

2. FULL NAME Dicey E. Bonham

(a) Residence. No. 820 E. Delmont St., ..... Ward. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U.S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

## PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): Widow

5a. IF MARRIED, WIDOWED, OR DIVORCED
HUSBAND OF
(OR) WIFE OF ✓

6. DATE OF BIRTH (MONTH, DAY AND YEAR) April 8-1841

7. AGE: Years 86 | Months 0 | Days 11 | If LESS than 1 day, ..... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: House Work
(b) General nature of industry, business, or establishment in which employed (or employer): .....
(c) Name of employer: .....

9. BIRTHPLACE (CITY OR TOWN) Ill
(STATE OR COUNTRY)

PARENTS

10. NAME OF FATHER Lafayette Hartley

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Unknown
(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER Sarah Hurst

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Unknown
(STATE OR COUNTRY)

14. INFORMANT Mrs. J. E. Forsythe
(Address) Springfield, Mo.

15. FILED 4/20 1927 O. C. Hoss Mee
REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 4-19-1927

17. I HEREBY CERTIFY, That I attended deceased from 4-17-1927 to 4-19-1927, that I last saw h. alive on 4-18-1927 and that death occurred, on the date stated above, at 11:30 P. M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Angina Pectoris

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) Cardio Vascular Disease

..... (duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED Home
IF NOT AT PLACE OF DEATH .....

DID AN OPERATION PRECEDE DEATH? no DATE OF .....

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? Clinical Symptoms

(Signed) Henry F. Kraft, M. D.

4/20, 1927 (Address) 500 1/2 E. Court

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL: El Dorado Kansas — DATE OF BURIAL: April 22 1927

20. UNDERTAKER: J. W. Lingner & Co. — ADDRESS: 420 E. Grand Springfield, Mo.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.