66

APR 26 1929

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

Do not use this space.

11558

1. PLACE OF DEATH Miller
County Miller
Township Richwood
City ..... (No. ..... St. ..... Ward)

Registration District No. 562
Primary Registration District No. 5757

File No. .....
Registered No. .....

2. FULL NAME Bonnie Driver

(a) Residence. No. ..... 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 Colored

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

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 3/24/29

7. AGE

YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
		2	

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

9. BIRTHPLACE (CITY OR TOWN) Miller Co. Mo.
(STATE OR COUNTRY)

PARENTS

10. NAME OF FATHER Wm Driver

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

12. MAIDEN NAME OF MOTHER Williams

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Miller Co. Mo
(STATE OR COUNTRY)

14. INFORMANT Will Driver
(Address) Iberia Mo

15. FILED 4/10, 1929 W. A. Von Grump
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 3/26 1929

17. I HEREBY CERTIFY, That I attended deceased from 3/24, 1929, to 3/26, 1929 that I last saw her alive on 3/26, 1929, and that death occurred, on the date stated above, at 1 p.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Septic infection of cord
(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) 162
(duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH .....
DID AN OPERATION PRECEDE DEATH? ..... DATE OF .....
WAS THERE AN AUTOPSY? .....
WHAT TEST CONFIRMED DIAGNOSIS? .....

(Signed) G W Duncan, M. D.
3/27, 1929 (Address) Iberia, Mo.

*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 Oakview Cem.

DATE OF BURIAL 3/27 1929

20. UNDERTAKER C. L. Adsey

ADDRESS Iberia 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.