

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

Do not use this space.

37757

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23 1929

538
6230

PLACE OF DEATH

County Madison Registration District No. 538 File No.
 Township Miss La Motte Primary Registration District No. 6230 Registered No.
 City Miss La Motte St. Ward)

2. FULL NAME Nancy Ann Bonds
 (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. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F **4. COLOR OR RACE** w. **5. SINGLE, MARRIED, WIDOWED OR DIVORCED** (write the word) widowed
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Geo. Bonds
6. DATE OF BIRTH (MONTH, DAY AND YEAR) 11
7. AGE YEARS MONTHS DAYS **IF LESS than 1 day, hrs. or min.**
70 1 10

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) Madison Co.
 (STATE OR COUNTRY) Mo.

10. NAME OF FATHER Geo Davis
11. BIRTHPLACE OF FATHER (CITY OR TOWN) Tenn.
 (STATE OR COUNTRY)
12. MAIDEN NAME OF MOTHER Mary Stone
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Unknown
 (STATE OR COUNTRY)

14. INFORMANT Mrs Frank Partee
 (Address) Fredericktown Mo.

15. FILE NO. 1030.29 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Nov 8 1929
17. I HEREBY CERTIFY, That I attended deceased from Sept. 8, 1929, to Nov. 8, 1929, and that I last saw her alive on Nov. 8, 1929, and that death occurred, on the date stated above, at

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Apoplexy
 (duration) - yrs. - mos. - da.
CONTRIBUTORY (SECONDARY) Apoplexy
 (duration) - yrs. - mos. - da. 3

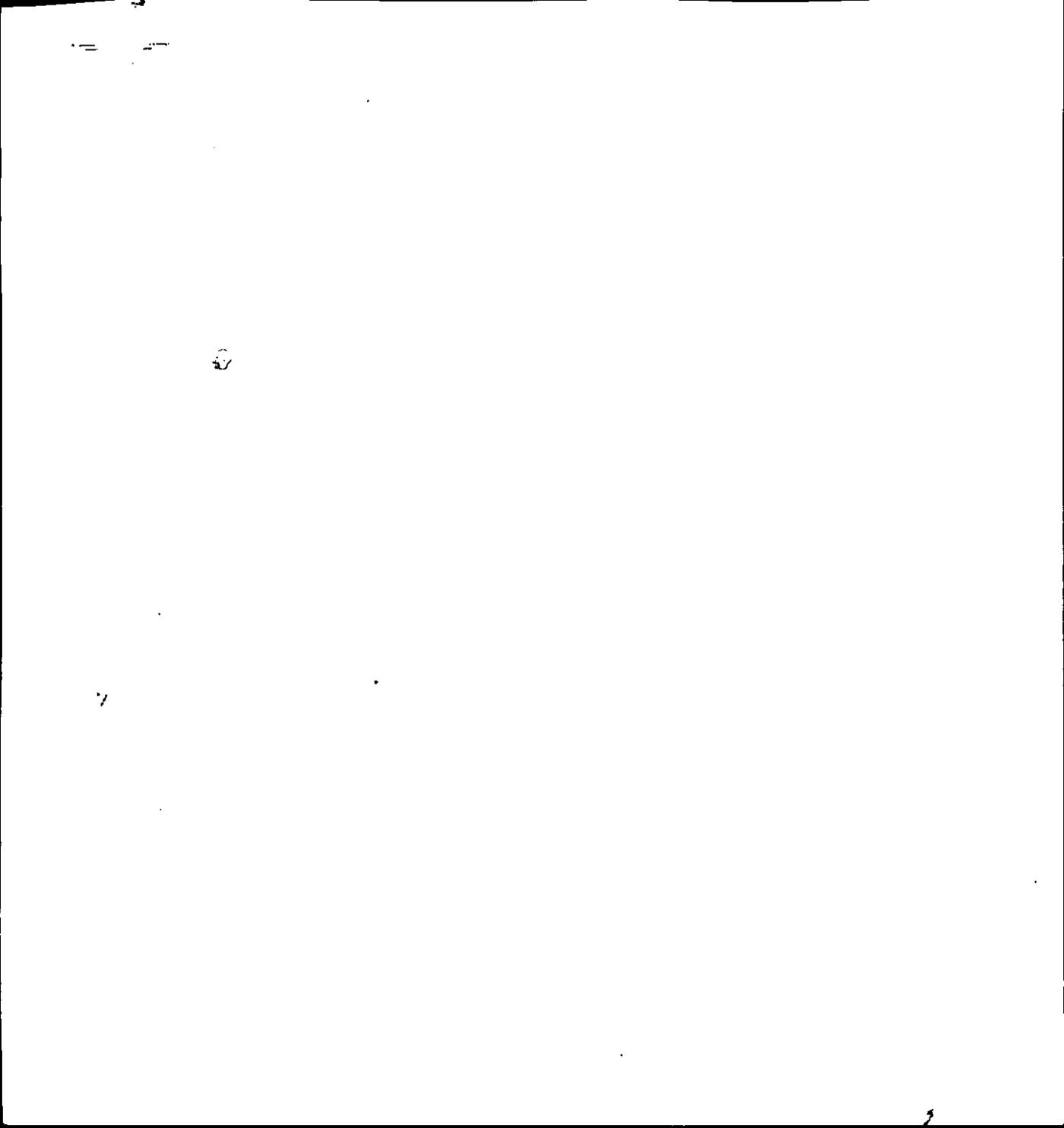
18. WHERE WAS DISEASE CONTRACTED? IF NOT AT PLACE OF DEATH
 (Did an operation precede death? DATE OF)
 WAS THERE AN AUTOPSY?
 WHAT TEST CONFIRMED DIAGNOSIS? (Signed) E. E. Higdon, M. D.
Nov. 10, 1929 (Address) Fredericktown, Mo.

*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 J. C. C. F. Cem. Farm. **DATE OF BURIAL** Nov 10 1929

20. UNDERTAKER E. H. Webb, Fredericktown, Mo.
 ADDRESS

235
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**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

ALL INFORMATION CALLED
FOR MUST BE WRITTEN ON
THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County Madison Registration District No. 538 File No. _____
 Township _____ Primary Registration District No. 6230 Registered No. _____
 City Mine La Motte (No. _____) St. _____ Ward _____

2. FULL NAME

(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. da. How long in U. S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED W
(write the word)

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 11/859 28

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
70 1 10

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) _____
 (STATE OR COUNTRY) _____

10. NAME OF FATHER _____
 11. BIRTHPLACE OF FATHER (CITY OR TOWN) _____
 (STATE OR COUNTRY) _____
 12. MAIDEN NAME OF MOTHER _____
 13. BIRTHPLACE OF MOTHER (CITY OR TOWN) _____
 (STATE OR COUNTRY) _____

14. INFORMANT _____
 (Address) _____

15. 11-30 1924 C. Y. Jones
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Nov 8 1929

17. I HEREBY CERTIFY That I attended deceased from _____
 19____ to _____, 19____
 that I last saw h. _____ alive on _____, 19____, and that
 death occurred, on the date stated above, at _____ m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

CONTRIBUTORY (SECONDARY) _____
 (duration) yrs. mos. da. _____
 (duration) yrs. mos. da. _____

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) _____, M. D.
 , 19 (Address) _____

*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 _____ DATE OF BURIAL _____
 19 _____

20. UNDERTAKER _____ ADDRESS _____

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED

SUPPLEMENTARY

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