

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

Do not use this space.

18302

1. PLACE OF DEATH

County Scott
Township Hammonds
City Benton (No.) St. Ward)

Registration District No. 814
Primary Registration District No. 4490

File No.
Registered No. 8

2. FULL NAME

Mollie Julia Bonnyfon
(a) Residence. No. Benton Mo 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 Female 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) widowed

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND or (or) WIFE of Charles F Bonnyfon

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Nov-9-1844

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, _____ hrs. or _____ min.
	85	6	2	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work House keeper
(b) General nature of industry, business, or establishment in which employed (or employer) None
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) Scott County Mo
(STATE OR COUNTRY)

10. NAME OF FATHER

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

12. MAIDEN NAME OF MOTHER Melissa Silman

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Scott Co.
(STATE OR COUNTRY) mo

14. INFORMANT O.E. Bonnyfon
(Address) Charleston, Mo.

15. FILED May 11, 1930 R. Wade REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) May 11 1930

17. I HEREBY CERTIFY, That I attended deceased from April 25, 1930 to May 11, 1930 that I last saw her alive on May 11, 1930, and that death occurred, on the date stated above, at 1:20 p.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Chronic interstitial nephritis
131
107A (duration) yrs. mos. da.
CONTRIBUTORY (SECONDARY) Broncho pneumonia with asthma
(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) Wesley P. Haw M. D.

, 19 (Address) Benton 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 Benton Cemetery DATE OF BURIAL May 12, 1930
20. UNDERTAKER O.D.M. Gupston ADDRESS Morley, 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.

1950

1950

1950

1950

**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 Scott Registration District No. 814 File No.
 Township Primary Registration District No. 4490 Registered No.
 City Benton (No.) City St. Ward)

2. FULL NAME Mollie Julia Bonneson
 (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 F 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write the word*) wid

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

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

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

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) May 11 1930

17. I HEREBY CERTIFY, That I attended deceased from 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:

 (duration) yrs. mos. ds.
 CONTRIBUTORY (SECONDARY) (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)....., M. D.
 , 19 (Address)

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

10. NAME OF FATHER Edwards

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) not known

12. MAIDEN NAME OF MOTHER

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

14. INFORMANT Julia E. Hassel
 (Address) Benton, Mo.

15. FILED July 8, 1930 SSW
 REGISTRAR

*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
 ADDRESS 19

20. UNDERTAKER ADDRESS

SUPPLEMENTARY

N. B.—Exact 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. REGISTRARS SHOULD NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

S-18302