

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

in this space.

19501

1. PLACE OF DEATH

County Jackson
Township Kaw
City Kansas City

Registration District No. 399
Primary Registration District No. 1002
(No. K.C. General Hospital)

File No. 2497
Registered No. 2497
St. _____ Ward _____

2. FULL NAME William Bonner

(a) Residence. No. 39th & Summitt St. 5 Ward _____

(Usual place of abode) Length of residence in city or town where death occurred 2 yrs. _____ mos. _____ ds. How long in U. S., if of foreign birth? _____ yrs. _____ mos. _____ ds. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male	4. COLOR OR RACE White	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Widower
-----------------------	----------------------------------	--

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF
Not Known

6. DATE OF BIRTH (MONTH, DAY AND YEAR) **Not Known**

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, _____ hrs. or _____ min.
About 70				

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. **Nite Watchman**
(b) General nature of industry, business, or establishment in which employed (or employer).
(c) Name of employer **Summitt Cleaners**

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **Not Known**

10. NAME OF FATHER **Not Known**

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) **Not Known**

12. MAIDEN NAME OF MOTHER **Not Known**

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) **Not Known**

14. INFORMANT K.C. General Hospital
(Address) Kansas City, Mo

15. FILED 9/16, 19 20 M. M. Craven
REGISTRAR Arar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 6-13 1950

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:

Accidental 3rd degree Burns
No employment
1941 (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? No DATE OF _____

WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS? History & Physical

(Signed) Paul M. Hall, M. D.

1/3 . 19 30 (Address) Deputy Coroner

*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 **Sheffield Cemetary** DATE OF BURIAL **6-15-30** 1950

20. UNDERTAKER **J.P. Louis, Funeral Director, City.** ADDRESS _____

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.

