

JAN 23 1935

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

Do not use this space.

39572

1. PLACE OF DEATH

County Jackson
Township New
City Keokuk

Registration District No. 379
Primary Registration District No. 1002

File No. 4710
Registered No. 4710
St. Ward

2. FULL NAME

(a) Residence, No. 905 Garfield
(Usual place of abode) Ward.

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. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE Colored
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED Married

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Aug 10 1900

7. AGE YEARS 35 MONTHS 4 DAYS 2 hrs. IF LESS than 1 day, hrs. or min.

OCCUPATION 8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Janitor
9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.
10. Date deceased last worked at this occupation (month and year)
11. Total time (years) spent in this occupation.

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ark.

MOTHER 13. NAME Don't Know

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Don't Know

15. MAIDEN NAME Don't Know

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Don't Know

17. INFORMANT Katie Bonner (ADDRESS) 905 Garfield.

18. BURIAL, CREMATION, OR REMOVAL PLACE Fort Smith, Ark. DATE Dec. 12 1935

19. UNDERTAKER (ADDRESS) West, Appleton & Jones 1604 1/2 E. St.

20. FILED Dec 12 1935 M. M. Crowder Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Dec 10 1935

22. I HEREBY CERTIFY, That I attended deceased from 11-28-35 to Dec 10 1935
I last saw him alive on Dec 29 1935 Death is said to have occurred on the date stated above at 2:10 p.m.
The principal cause of death and related causes of importance were as follows:

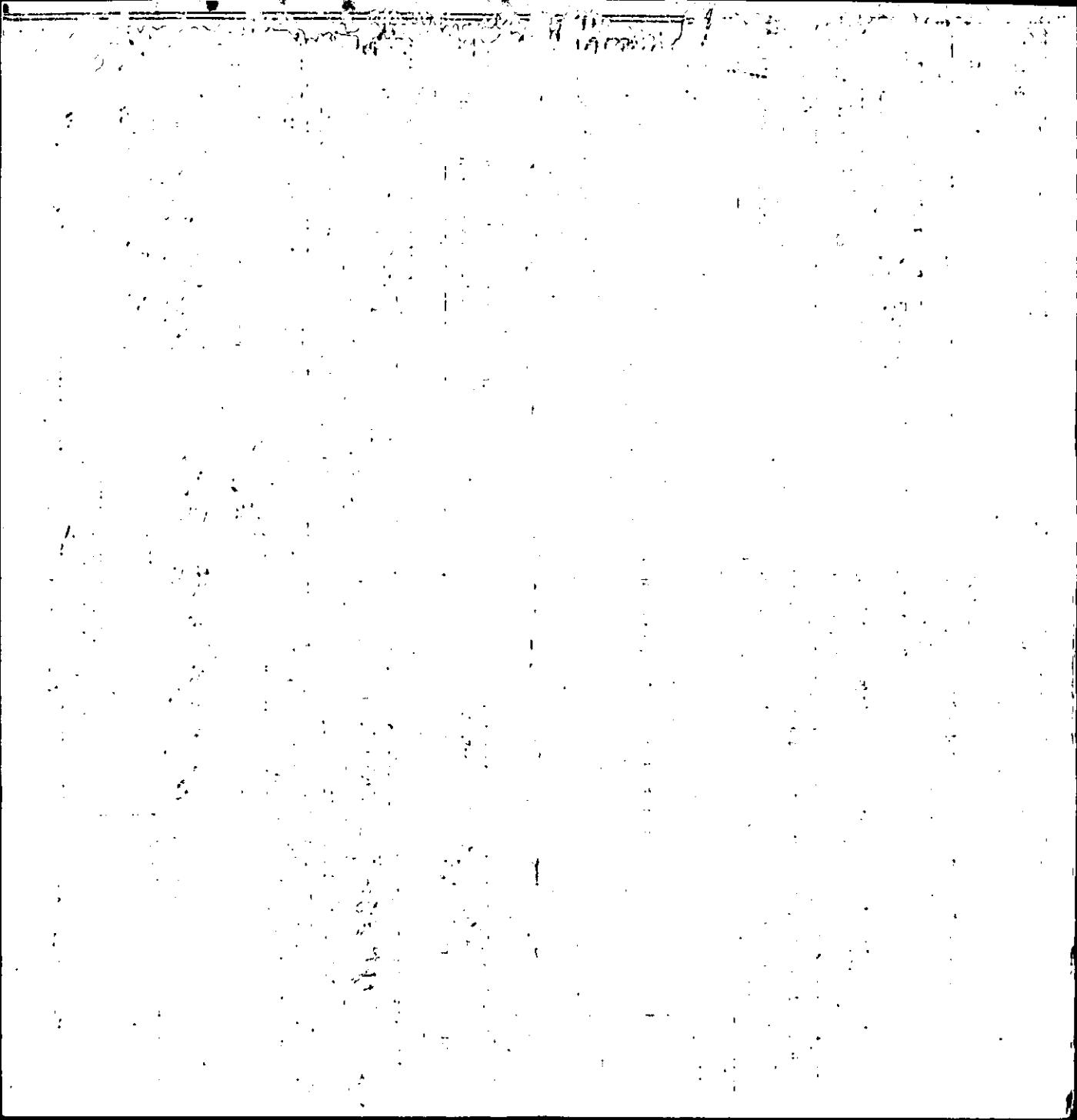
Other contributory causes of importance:
Myocarditis
Bronchial Asthma
Date of onset 12-5-35

Name of operation
What test confirmed diagnosis? Culture Was there an autopsy? Yes

23. If death was due to external causes (violence), fill in also the following: Accident, suicide, or homicide? No Date of injury, 19...
Where did injury occur? (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury
Nature of injury

24. Was disease or injury in any way related to occupation of deceased? No
If so, specify
(Signed) H. Rinder, M. D.
(Address) 1722 1/2 E. 18



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

Do not use this space.

1. PLACE OF DEATH

County..... Registration District No.....
Township..... Primary Registration District No.....
City..... (No. *905*) *Barfield*..... St. Ward)

File No.....
Registered No. *4714*
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. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

Wesley Bonner

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <i>Male</i>	4. COLOR OR RACE <i>Col</i>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <i>Married</i>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF		
6. DATE OF BIRTH (MONTH, DAY, AND YEAR)		
7. AGE <i>35</i>	YEARS	MONTHS
		DAYS
		If LESS than 1 day, hrs. or min.

OCCUPATION	8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.
	9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.
	10. Date deceased last worked at this occupation (month and year)
	11. Total time (years) spent in this occupation

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

13. NAME

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

15. MAIDEN NAME

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

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL PLACE DATE 19.....

19. UNDERTAKER (ADDRESS)

20. FILED *Dec 12 1935* *M. M. Brown* Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *Dec 10*, 19*35*

22. I HEREBY CERTIFY, That I attended deceased from 19....., to 19.....

I last saw h..... alive on....., 19..... Death is said to have occurred on the date stated above, at..... m.

The principal cause of death and related causes of importance were as follows:

Myocardial Acute Date of onset *12/7/35*

Other contributory causes of importance: *Bronchial Asthma* *1/2*

Name of operation..... Date of.....

What test confirmed diagnosis?..... Was there an autopsy?.....

23. If death was due to external causes (violence), fill in also the following: Accident, suicide, or homicide?..... Date of injury..... 19.....

Where did injury occur?..... (Specify city or town, county, and State) Specify whether injury occurred in industry, in home, or in public place.

Manner of injury.....

Nature of injury.....

24. Was disease or injury in any way related to occupation of deceased?.....

If so, specify. (Signed) *N. Binder*, M. D.

(Address) *1722 1/2 E. 18*

S-39572