

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

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

REC'D MAR 16 1939

7925  
Do not use this space.

1. PLACE OF DEATH

(a) County Paline Registration District No. 792  
(b) Township Arrow Rock Primary Registration District No. 4473  
(c) City \_\_\_\_\_ (d) Street No. 1135 Registered No. \_\_\_\_\_  
(If death occurred in Hospital or Institution, write its name instead of street and number) St. \_\_\_\_\_  
(e) Length of residence in city or town where death occurred yrs. mos. da. (f) How long in U. S., if of foreign birth? yrs. mos. da.

2. PRINT FULL NAME

(a) Residence, No. \_\_\_\_\_ St.  (If nonresident, give city or town and State)  
Herschel Lee Bond

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

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

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Feb. 18, 1939

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

22. I HEREBY CERTIFY, That I attended deceased from Feb 18, 1939, to Feb 18, 1939

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Feb. 18<sup>th</sup> 1939

I last saw him alive on Feb 18, 1939. Death is said to have occurred on the date stated above, at 1:30 p.m.

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min. 19 yrs. 11 mos. 5 min.

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

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

Premature Birth  
159'  
Date of onset 2/18/39  
Other contributory causes of importance:  
The mother had influenza - caused the premature birth.

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

Name of operation \_\_\_\_\_ Date of \_\_\_\_\_  
What test confirmed diagnosis? \_\_\_\_\_ Was there an autopsy?

FATHER 13. NAME John C. Bond

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

MOTHER 15. MAIDEN NAME Jannet L. Cooper

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

17. INFORMANT (ADDRESS) John C. Bond  
Wilson mo

18. BURIAL, CREMATION, OR REMOVAL PLACE Arrow Rock Ariz Feb. 19, 1939

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Campbell Lewis  
Marshall mo

20. FILED Feb. 25, 1939 C. R. Rawles  
Local Registrar.

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) Dr. T. Buckler, M. D. O.  
(Address) Marshall mo.

RECEIVED  
District Health Officer No. 8,  
District File Number  
Filed 2/13/29

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**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, .....

....., or by .....

Registered Apprentice No. ...., working under my personal supervision.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

**Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)**

**If this body is not embalmed, above space should be left blank.**