

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.

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

1899 OCT 16 1939

33296
Do not use this space.

1. PLACE OF DEATH

(a) County Putnam Registration District No. 718
(b) Township Unionville Primary Registration District No. 6430 Registered No. 36
(c) City Unionville Street No. _____ St. _____
(If death occurred in Hospital or Institution, write its name instead of street and number)
(e) Length of residence in city or town where death occurred yrs. mos. ds. (6) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

(a) Residence, No. _____ St. _____
(Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED Married
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Jacob Bonebright
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 1-14-1846
7. AGE YEARS 93 MONTHS 8 DAYS 11 If LESS than 1 day, _____ hrs. or _____ min.

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

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

13. NAME Paul H. Harbert

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

15. MAIDEN NAME Sarah Guthrie

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

17. INFORMANT (ADDRESS) A. J. Bonebright
Unionville

18. BURIAL, CREMATION, OR REMOVAL PLACE West Liberty DATE Sept 27, 1939

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Hicks & Son
Unionville, Mo.

20. FILED Sept 30, 1939 W. W. Sellen
Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Sept 25, 1939

22. I HEREBY CERTIFY, That attended deceased from Sept 12, 1939 to Sept 25, 1939

I last saw her alive on Sept 25, 1939. Death is said

to have occurred on the date stated above, at 8:30 A. M.

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

Date of onset

92.0
Myocardial degeneration

Other contributory causes of importance:

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 _____

(Signature) W. W. Sellen M. D.

(Address) Unionville, Mo.

RECEIVED

District Health Officer. No. 10

District File Number 10-39-1715

Date Filed OCT 3 1939

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.....

JO Husted

Licensed Embalmer No.....

2975

P. O. Address.....

Unionville N.C.

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.