

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
STANDARD CERTIFICATE OF DEATH

State File No. 40788

Registration District No. 784

Primary Registration District No. 200

Registrar's No. 2118

1. PLACE OF DEATH:
 (a) County St. Louis
 (b) City or town Koch
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: Robert Koch Hospital 1
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 1 year
 (Specify whether years, months or days) 17 years

2. USUAL RESIDENCE OF DECEASED:
 (a) State Mo. 1 (b) County St. Louis
 (c) City or town St. Louis
 (If outside city or town limits, write "RURAL")
 (d) Street No. 3957 Finney
 (If rural, give location)
 (e) If foreign born, how long in U. S. A? _____ years.

3. (a) PRINT FULL NAME William Bon Durant, Sr.
 3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month July day 12 year 1939 hour 3 minute 30 A.M.
 21. I hereby certify that I attended the deceased from 7-1-39, 1939, to 12-1-, 1939;
 that I last saw him alive on 11-30-39, 1939;
 and that death occurred on the date and hour stated above.

4. Sex M. 5. Color or race W. 3
 6. (a) Single, widowed, married, divorced Married
 6. (b) Name of husband or wife Mary Bon Durant
 6. (c) Age of husband or wife if alive _____ years
 7. Birth date of deceased July 4 1906
 (Month) (Day) (Year)

Immediate cause of death Pulmonary Tuberculosis Duration 2 years
Th. of G.T. tract?
 Due to Generalized Amyloidosis?
 Due to _____
 Other conditions (include pregnancy within 3 months of death) 231

8. AGE: Years Months Days If less than one day
33 4 27 hr. min.

Major findings: Of operations _____
 Of autopsy Pulmonary Th. Amyloidosis
 Underline the cause to which death should be charged statistically.

9. Birthplace Columbus Ky. 1
 (City, town, or county) (State or foreign country)
 10. Usual occupation Maintenance Man
 11. Industry or business _____

22. If death was due to external causes, fill in the following:
 (a) Accident, suicide, or homicide (specify) _____
 (b) Date of occurrence _____
 (c) Where did injury occur? _____ (City or town) (County) (State)
 (d) Did injury occur in or about home, on farm, in industrial place, in public place?
 While at work? _____ (Specify type of place) (e) Means of injury _____
 23. Signature Robert Kaplan (M. D. or other) _____
 Address Koch 784 Date signed 12-1-39

MOTHER FATHER
 12. Name George Bon Durant 1
 13. Birthplace Dresden Tenn
 (City, town, or county) (State or foreign country)
 14. Maiden name Jula Straus
 15. Birthplace Louisville Ky
 (City, town, or county) (State or foreign country)
 16. (a) Informant's own signature Mary Bon Durant
 (b) Address 3957 Finney Ave
 17. (a) Burial (b) Date thereof 12-4-39
 (Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation Washington Park Cem
 18. (a) Signature of funeral director Peoples and Co.
 (b) Address 7100 Franklin Ave
 19. (a) DEC 4 1939 (b) A. R. Meyer M.D. R.D.
 (Date received local registrar) (Registrar's signature)

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 Robert A. Powell.

Licensed Embalmer No. 3402

P. O. Address 3100 Franklin

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.