

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.

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

43785

Registration District No. 441

Primary Registration District No. 4269

State File No. \_\_\_\_\_

Registrar's No. 72

1. PLACE OF DEATH:

- (a) County Knox  
(b) City or town Edina  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: 2  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 27 yrs. (Specify whether years, months or days)  
In this community 27 yrs.

3. (a) PRINT FULL NAME Emma Amanda Bondurant. 536

8. (b) If veteran, name war \_\_\_\_\_ 8. (c) Social Security No. \_\_\_\_\_

4. Sex F 5. Color or race White 6. (a) Single, widowed, married, divorced Widowed  
6. (b) Name of husband or wife Thomas Allen Bondurant. 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased August-22-1850. (Month) (Day) (Year)

8. AGE: Years 89 Months 3 Days 23 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace Terre Haute Ind (City, town, or county) (State or foreign country)

10. Usual occupation Housekeeper

11. Industry or business \_\_\_\_\_

12. Name T.J. Hall  
13. Birthplace Terre Haute Ind (City, town, or county) (State or foreign country)  
14. Maiden name Rebecca Galloway  
15. Birthplace uk So. Carolina (City, town, or county) (State or foreign country)

16. (a) Informant's own signature Flo Hickman  
(b) Address Bourbon Mo.  
17. (a) Burial. (b) Date thereof Dec 16/39 (Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation Labelle, Mo.

18. (a) Signature of funeral director Patricia Hudson  
(b) Address Edina Mo. 305  
19. (a) Dec 16/39 (b) Mrs. C.M. Smith (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

- (a) State Mo. (b) County Knox.  
(c) City or town Edina. (If outside city or town limits, write "RURAL")  
(d) Street No. \_\_\_\_\_ (If rural, give location)  
(e) If foreign born, how long in U. S. A.? \_\_\_\_\_ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 15 year 1939. hour 5 minute 0 M.  
21. I hereby certify that I attended the deceased from Dec 13/39 to Dec 15 1939.  
that I last saw her alive on Dec 15 1939.  
and that death occurred on the date and hour stated above.  
Immediate cause of death Cerebral Hemorrhage Duration \_\_\_\_\_

Due to Hypertension  
Due to 87.1k  
Other conditions \_\_\_\_\_ (Include pregnancy within 3 months of death)  
Major findings: \_\_\_\_\_  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_  
Underline the cause to which death should be charged statistically

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 G.E. Luman (M. D. or other) \_\_\_\_\_  
Address Edina Mo Date signed 12/16/39

RECEIVED

District Health Officer No. 10

District File Number 1-40-11

Date Filed JAN 9 1940

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. 2415

P. O. Address Edina, Mo.

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.