

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

10784
Do not use this space.

1. PLACE OF DEATH
 (a) County Kansas Registration District No. 241
 (b) Township W. Barton Primary Registration District No. 5554 Registered No. 1259
 (c) City _____ (d) 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. (f) How long in U.S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Eusebia Henderson Bonnell
 (a) Residence, No. _____ St. (If nonresident, give city or town and State)
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX m 4. COLOR OR RACE w 5. SINGLE, MARRIED, OR DIVORCED (write the word) married

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 12-2-1903

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
36 2 14

OCCUPATION
 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Taxi
 9. Industry or business in which work was done, as saw mill, bank, etc. Driver
 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) Buffalo mo.

FATHER
 13. NAME W.W. Bonnell
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Unknown

MOTHER
 15. MAIDEN NAME Anna Jasper
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Unknown

17. INFORMANT (ADDRESS) Rosa Bonnell
Buffalo mo

18. BURIAL, CREMATION, OR REMOVAL PLACE Grav. Kaum DATE 2-18 19. Y

19. FUNERAL DIRECTOR (NAME) (ADDRESS) L.B. Jones
Buffalo mo

20. FILED 2/20 19. 40 Hanny Morn
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 2-16 1940

22. I HEREBY CERTIFY, That I attended deceased from Fri. January 26, 1940, to Fri. January 16, 1940
 I last saw him alive on Fri. January 16, 1940. Death is said to have occurred on the date stated above, at 10 P.M.
 The principal cause of death and related causes of importance were as follows:
Pulmonary Hemorrhage ✓
 Date of onset 2-15-40

Other contributory causes of importance:
Tubercular Meningitis 1-26-40

Name of operation _____ Date of _____
 What test confirmed diagnosis? _____ Was there an autopsy? no.

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? no.
 If so, specify _____
 (Signed) E. Williams M.D.
 (Address) Buffalo, Missouri

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

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.

1 X 16805

RECEIVED
District Health Officer No. 7,
District File Number H-40-570
Date Filed H-1-10

STATE HEALTH DEPARTMENT
DIVISION OF HEALTH SERVICES

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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 10784

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. 241

Primary Registration District No. 5337

Registrar's No. _____

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:
(a) County Dallas
(b) City or town W Benton
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community _____ (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State _____ (b) County _____
(c) City or town _____ (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.

3. (a) PRINT FULL NAME Eusebius Henderson Bonnell
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month 2 day 16 year 1940 hour _____ minute _____ M.
21. I hereby certify that I attended the deceased from _____ 19 _____ to _____ 19 _____ that I last saw him _____ alive on _____ 19 _____ that death occurred on the date and hour stated above.

4. Sex m 5. Color or race w 6. (a) Single, widowed, married, divorced m
6. (b) Name of husband or wife _____ 6. (c) Age of husband, or wife, if alive _____ years
7. Birth date of deceased: (Month) _____ (Day) _____ (Year) _____

Immediate cause of death Pulmonary tuberculosis
Duration _____

8. AGE: Years 36 Months 2 Days 14 If less than one year _____ hr. _____ min.

Due to Pulmonary tuberculosis
Due to _____

9. Birthplace: (City, town, or county) _____ (State or foreign country) _____

Other conditions: Tubercular meningitis
(Include pregnancy within 3 months of death)

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 12. Name _____
13. Birthplace: (City, town, or county) _____ (State or foreign country) _____
14. Maiden name _____ (State or foreign country) _____
15. Birthplace: (City, town, or county) _____ (State or foreign country) _____

Major findings: Of operations 77
Of autopsy _____
PHYSICIAN _____ Underline the cause to which death should be charged statistically.

16. (a) Informant _____ (b) Address _____

22. If death was due to external causes, fill in the following:

17. (a) _____ (b) Date thereof _____ (Month) (Day) (Year)
(Burial, cremation, or removal) _____
(c) Place: burial or cremation _____

(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? _____

18. (a) Signature of funeral director _____ (b) Address _____

While at work? _____ (Specify type of place) (c) Means of injury _____

19. (a) _____ (b) _____ (Date received local registrar) (Registrar's signature)

23. Signature E. L. Williams (M. D. or other) _____
Address Buffalo _____ Date signed _____

SUPPLEMENTARY

S-10784