

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No.

Registrar's No. 46

FILED MAR 3 1943

Registration District No. 39

Primary Registration District No. 4097

1. PLACE OF DEATH:

(a) County Cass
(b) City or town Harrisonville
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 1 (Specify whether years, months or days) (Specify whether years, months or days)

3. (a) PRINT FULL NAME Bonnie Frances Ament

3. (b) If veteran, ✓ name war ✓ 3. (c) Social Security No. ✓

4. Sex Female 5. Color or race white 6. (a) Single, widowed, married, 2 divorced children

6. (b) Name of husband or wife Thomas McElroy Ament 6. (c) Age of husband or wife if alive 1 years

7. Birth date of deceased Feb 7 - 1898
(Month) (Day) (Year)

8. AGE: Years 85 Months — Days 24 If less than one day ✓ hr. ✓ min.

9. Birthplace Cass Co. Mo.
(City, town, or county) (State or foreign country)

10. Usual occupation Home maker

11. Industry or business

12. Name Jessie N. Ament

13. Birthplace Cass Co. Mo.
(City, town, or county) (State or foreign country)

14. Maiden name Amanda Ament

15. Birthplace Cass Co. Mo.
(City, town, or county) (State or foreign country)

16. (a) Informant Myself

(b) Address Harrisonville Mo.

17. (a) Rural (b) Date thereof Feb 28 1943
(Burial, cremation or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Burial Cemetery

18. (a) Signature of funeral director RENNENBURGER'S
(b) Address HARRISONVILLE, MO.

19. (a) Feb 28, 1943 (b) Margaret Wells
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County Cass
(c) City or town Harrisonville
(If outside city or town limits, write "RURAL")
(d) Street No. 808-5 Lexington
(If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country no

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb day 28
year 1943 hour 12 minute noon

21. I hereby certify that I attended the deceased from Jan 2 1943 to Feb 25 1943
that I last saw her alive on Feb 25 1943
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Hemorrhage
Due to Arterial Hypertension
Due to Arterial Hypertension

Other conditions (Include pregnancy within 3 months of death) GBA

Major findings: Of operations

Of autopsy

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

(a) Accident, suicide, or homicide (specify) no
(b) Date of occurrence no
(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 no

23. Signature J. S. Trish (M. D. or other)
Address Harrisonville Mo. Date signed 2/27/43

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

MAR 17 1943

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 _____

Ernest R. Rinnemeyer

Licensed Embalmer No. *3368*

P. O. Address *Harrisonville 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, fact should be so stated above.