

S. No. 2
OM-241
5-1-38
I X35597

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

26491

State File No.

FILED AUG 30 1943 18

1003

Registrar's No.

7510

Registration District No.

Primary Registration District No.

1. PLACE OF DEATH:

(a) County St. Louis
(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
BARNES HOSPITAL
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community 2 mo 9 days (Specify whether)
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Illinois (b) County Madison
(c) City or town R 2 Collinsville Ills
(If outside city or town limits, write "RURAL")
(d) Street No. none (If rural, give location)
(e) Citizen of foreign country? yes (Yes or No)
If yes, name country 2

3. (a) PRINT FULL NAME Tabea Bonn

3. (b) If veteran, name war no 3. (c) Social Security No. none

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

6. (b) Name of husband or wife Albert F. Bonn 6. (c) Age of husband or wife if alive 60 years

7. Birth date of deceased Oct 9th 1880
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
62 10 11 _____ hr. _____ min.

9. Birthplace Collinsville, Ills.
(City, town, or county) (State or foreign country)

10. Usual occupation housework

11. Industry or business at home

MOTHER FATHER { 12. Name John Otto
13. Birthplace Not known
(City, town, or county) (State or foreign country)

14. Maiden name not known
15. Birthplace not known
(City, town, or county) (State or foreign country)

16. (a) Informant Albert F. Bonn
(b) Address Collinsville, Ills. R 2

17. (a) removal (Burial, cremation, or removal) (b) Date thereof Aug 21 1943
(Month) (Day) (Year)

(c) Place: burial or cremation Collinsville Ills

18. (a) Signature of funeral director Geo. M. Schroepfel

(b) Address Collinsville, Ills.

19. (a) AUG 21 1943 (b) J. F. Bredek
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug. day 20
year 1943 hour 7 minute 55 A.M.

21. I hereby certify that I attended the deceased from June 23, 1943 to Aug. 20, 1943
that I last saw her alive on Aug. 20, 1943
and that death occurred on the date and hour stated above.

Immediate cause of death Hemolytic staphylococcus
oris septicemia
Bronchopneumonia, bilateral
Due to Multiple myeloma

Due to _____
Other conditions _____
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____
Of autopsy As above

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 M. C. Abney (M. D. or other)
Address BARNES HOSPITAL Date signed 8/20/43

Duration
1 wk
8 mo
PHYSICIAN
Underline the cause to which death should be charged statistically.

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

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.....

Leo M. Schweppel

Licensed Embalmer No. 1598

P. O. Address Collinsville, Ills.,

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.