

SEP 11 1943 **42**

Primary Registration District No. **1000**

Registrar's No. **899**

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

1. PLACE OF DEATH:
(a) County **Buchanan**
(b) City or town **St. Joseph**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: **3224 Druid Park Road**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **no**
In this community **3 weeks** (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State **Missouri** (b) County **Buchanan**
(c) City or town **St. Joseph**
(If outside city or town limits, write "RURAL")
(d) Street No. **3224 Druid Park Road**
(If rural, give location) **HO**
(e) Citizen of foreign country? **no** (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME **Carol Ann Bonner**
(b) If veteran, name war **no** (c) Social Security No. **no**

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **August** day **7**
year **1943** hour **6** minute **P.**M.

4. Sex **female** 5. Color or race **white**
6. (a) Single, widowed, married, divorced **child**
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased **July 16, 1943**
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from **Aug. 4, 1943** 19____ to **Aug. 7, 1943** 19____
that I last saw her alive on **Aug. 7, 1943** 19____
and that death occurred on the date and hour stated above.

8. AGE:	Years	Months	Days	If less than one day
			23	_____hr. _____min.

Immediate cause of death **Acute Oedema of Pulmonary**
Due to **Whooping Cough** **10 ds**
Duration

9. Birthplace **St. Joseph, Mo.**
(City, town, or county) (State or foreign country)

Due to _____
Due to _____
Other conditions (Include pregnancy within 3 months of death) **9**

10. Usual occupation **child**

Major findings: Of operations _____
Of autopsy _____

11. Industry or business _____
12. Name **Chris Bonner Jr**
13. Birthplace **St. Joseph, Mo.**
(City, town, or county) (State or foreign country)

PHYSICIAN _____
Underline the cause to which death should be charged statistically.

14. Maiden name **Geraldine Etheridge**
15. Birthplace **Kansas City, Mo.**
(City, town, or county) (State or foreign country)

16. (a) Informant **Chris Bonner Jr**
(b) Address **3224 Druid Park Road**

17. (a) **Burial** (b) Date thereof **8-10-43**
(Burial, cremation, or removal) (Month) (Day) (Year)

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? _____

18. (a) Signature of funeral director **Tracy Barry Funeral Home**
(b) Address **212 So 10th St St Joseph Mo**
(Specify type of place)

23. Signature **J.R. Elliott** (M. D. or other) **M.D.**
Address **805 Francis, St. Joseph, Mo** Date signed **8-9-43**

19. (a) **8-10-43** (b) **Use Haggoy**
(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.....

Don Clark

Licensed Embalmer No.

P. O. Address.....

*4216
St Joseph*

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.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. Sept.

Registration District No. 42 Primary Registration District No. _____ Registrar's No. _____

1. PLACE OF DEATH:
 (a) County Buchanan
 (b) City or town _____
(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 years, months or days)

3. (a) PRINT FULL NAME Carol Ann Bonner
 3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

5. Color or race Female white
 6. (a) Single, widowed, married, divorced _____
 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)
 8. AGE: Years _____ Months _____ Days _____
If less than one day or min.

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 12. Name _____

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

14. Maiden name _____

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

16. (a) Informant _____

(b) Address _____

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

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

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

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) Citizen of foreign country? _____ (Yes or No)
 If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug year 1943 hour 3 minute 10 M.

21. I hereby certify that I attended the deceased from _____, 19____; that I last saw him _____, 19____; and that death occurred on the date and hour stated above. Immediate cause of death _____

Duration

Due to _____

Due to _____

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

Major findings:
 Of operations _____

Of autopsy _____

PHYSICIAN

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)

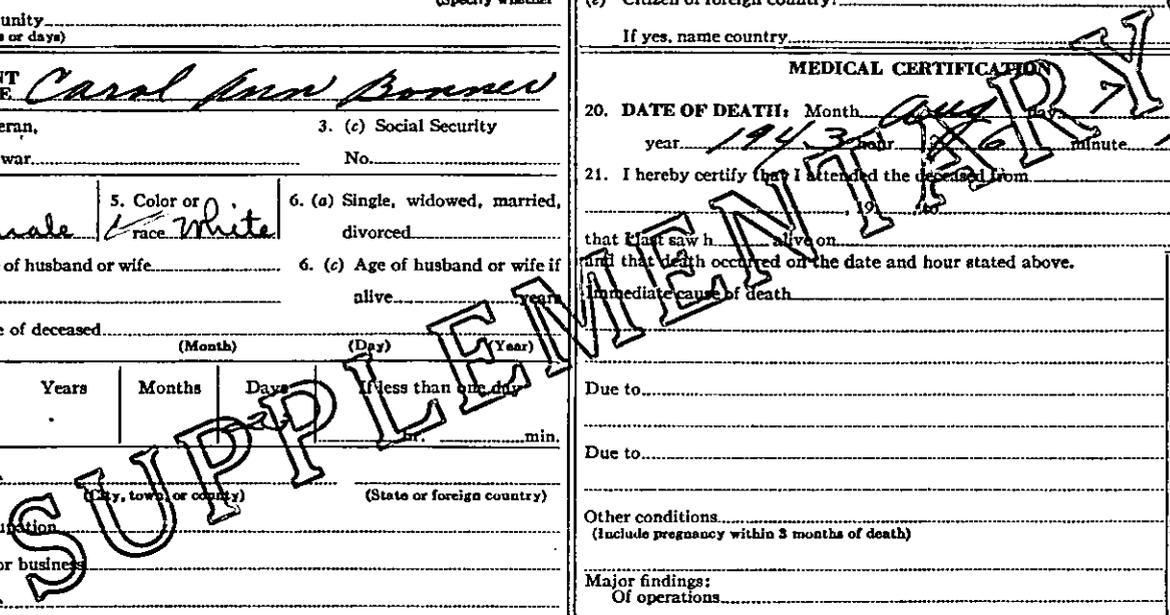
(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

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

23. Signature _____ (M. D. or other) _____

Address _____ Date signed _____

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



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