

Registration District No. _____

Primary Registration District No. **3002**

1. PLACE OF DEATH:

(a) County **Audrain**
(b) City or town **Mexico Mo.**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: **Audrain 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 **9 Months**
years, months or days)

3. (a) PRINT FULL NAME **Bonnie Sue Bishop.**

3. (b) If veteran, name war **None** 3. (c) Social Security No. **None**

4. Sex **Female** 5. Color or race **White** 6. (a) Single, widowed, married, divorced. **0**
6. (b) Name of husband or wife **X** 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased **June 9, 1943**
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
8 13 hr. min.

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

10. Usual occupation **None**

11. Industry or business _____

12. Name **Raymond B Bishop**

13. Birthplace **Lincoln County Mo.** (City, town, or county) (State or foreign country)

14. Maiden name **PEARL Helming.**

15. Birthplace **Boone County Mo.** (City, town, or county) (State or foreign country)

16. (a) Informant **Raymond B Bishop.**

(b) Address **1617. Southwestern St Mexico Mo.**

17. (a) **Burial** (b) Date thereof **2-25-1944**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Elmwood Mexico Mo.**

18. (a) Signature of funeral director **Carl E. Pugh**

(b) Address **Mexico, Mo.**

19. (a) **2/25/44** (b) **Margaret Mackie**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Audrain**
(c) City or town **Mexico-Mo.**
(If outside city or town limits, write "RURAL")
(d) Street No. **1617-Southwestern**
(If rural, give location)
(e) Citizen of foreign country? **8 Months - 15 Days** (Yes or No)
If yes, name country **Audrain**

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Feb** day **22nd**
year **1944** hour **9:30** minute **P** M.

21. I hereby certify that I attended the deceased from **Feb 20th**, 1944, to **Feb 22**, 1944;
that I last saw him alive on **Feb 22**, 1944;
and that death occurred on the date and hour stated above.

Immediate cause of death **Pneumonia (Influenza)** Duration **10 days?**

Due to **Upper respiratory infection and influenza**
Due to _____

Other conditions (Include pregnancy within 3 months of death) **33a**

Major findings: Of operations _____

Of autopsy _____

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 **0**

23. Signature **Harry J. Orman** (M. D. or other)

Address **Mexico Mo** Date signed **2-25-44**

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

MOTHER FATHER

RECEIVED

District Health Officer No. 10

District File Number 3-44-633

Date Filed MAR 10 1944

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.....

Earl E. Pracht, Registered Apprentice No.....

working under my personal supervision.

Signed..... Earl E. Pracht

Licensed Embalmer No. 3189

P. O. Address Mexico, 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.