

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED FEB 17 1944

Registration District No. 93

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 5342

State File No. 6995

Registrar's No. 13

1. PLACE OF DEATH:

(a) County Dade
(b) City or town South-Grainfield-Rural
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution Washington Hosp
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution all her life (Specify whether years, months or days)

3. (a) PRINT FULL NAME

Armando Bonles

3. (b) If veteran, name war L

3. (c) Social Security No. L

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced widow
6. (b) Name of husband or wife L 6. (c) Age of husband or wife if alive 2 years

7. Birth date of deceased (Month) unknown (Day) (Year)

8. AGE: Years 90 Months Days If less than one day hr. min.

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

10. Usual occupation House Keeper

11. Industry or business

12. Name John Steehy

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

14. Maiden name Rebecca Poindexter

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

16. (a) Informant Tom Bonles

(b) Address So. Grainfield Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-9-1943 (Month) (Day) (Year)

(c) Place: burial or cremation Pennsboro

18. (a) Signature of funeral director Monroe Senior

(b) Address Miller Mo.

19. (a) Jan 3 '44 (Date received local registrar) (b) Phyllis Lack (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Lawrence
(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 Oct. day 9 year 1943 hour 2 minute 1 M.

21. I hereby certify that I attended the deceased from Aug 9, 1943 to Oct, 1943, that I last saw him alive on Aug 28, 1943, and that death occurred on the date and hour stated above.

Immediate cause of death Senility & arteriosclerosis
Due to No Heart Failure or other
Due to Causes of death

Other conditions (Include pregnancy within 3 months of death)

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

23. Signature NE Brydman (M. D. or other)
Address Carthage Date signed Oct 18 1943

RECEIVED

District Health Officer No. 6;

District File Number 244-222

Date Filed FEB 15 1944

STATEMENT BY LICENSED EMBALMER

not Embalmed

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, fact should be so stated above.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____

Registrar's No. _____

FILED IN
117

Registration District No. 93

Primary Registration District No. 5342

13

1. PLACE OF DEATH

- (a) County Blade
(b) City or town Rural Washington
(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 _____
years, months or days

3. (a) PRINT
FULL NAME

Armanda Boulle

3. (b) If veteran,
name war _____

3. (c) Social Security
No. _____

4. Sex F 5. Color or W 6. (a) Single, widowed, married,
race _____ divorced _____
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if
alive _____ years

7. Birth date of deceased unk
(Month) (Day) (Year)

8. AGE: Years 90 Months _____ Days _____ If less than one day _____ min.
in _____

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

10. Usual occupation

11. Industry or business

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)

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) Phyllis Lack
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

- (a) State Ms. (b) County Lawrence
(c) City or town Rural
(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 Oct Day 19 Year 1943 hour _____ minute _____ M.
21. I hereby certify that I attended the deceased from _____ 19____;
that I last saw him _____ alive on _____ 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

6995