

EX-2  
8-43  
17-39  
X37823

FILED JAN 9 1945

Registration District No. 22

Primary Registration District No. 1500

Registrar's No. 1835

1. PLACE OF DEATH:

(a) County Buchanan

(b) City or town Saint Joseph  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:  
723 South 11 street (Nursing Home)  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution one week  
(Specify whether

In this community Since 1882  
years, months or days)

3. (a) PRINT FULL NAME James Albert Bond

3. (b) If veteran, name war

3. (c) Social Security No. NOISE

4. Sex Male 5. Color or race white

6. (a) Single, widowed, married, divorced Widower

6. (b) Name of husband or wife Mrs. Josephine P. Bond

6. (c) Age of husband or wife if alive 24 years

7. Birth date of deceased April 1859  
(Month) (Day) (Year)

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

85 7 17 hr. min.

9. Birthplace Randolph County Indiana  
(City, town, or county) (State or foreign country)

10. Usual occupation

11. Industry or business

MOTHER FATHER

12. Name Levi R. Bond

13. Birthplace Randolph County, Indiana  
(City, town, or county) (State or foreign country)

14. Maiden name Elizabeth Fignes

15. Birthplace Randolph County, Indiana  
(City, town, or county) (State or foreign country)

16. (a) Informant Sam Jim Bond

(b) Address 1211 South 9th Street

17. (a) Burial (b) Date thereof Dec. 13, 1944  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Ashland Cemetery

18. (a) Signature of funeral director Mar. E. S. IDENPAEDEN

(b) Address 602 South 10th Street

19. (a) 12-12-44 (b) Nelson D. Puckle  
(Date received local Registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Buchanan

(c) City or town Saint Joseph  
(If outside city or town limits, write "RURAL")

(d) Street No. 918 South 8th Street  
(If rural, give location)

(e) Citizen of foreign country? NO (Yes or No)

If yes, name country 1

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month December day 11th  
year 1944 hour 12 minute 30 A. M.

21. I hereby certify that I attended the deceased from November 28th  
December 10th, 1944 to December 10th, 1944  
that I last saw him alive on December 10th, 1944  
and that death occurred on the date and hour stated above.

Immediate cause of death

Chronic Bronchitis 2-3 mo.

Arteriosclerosis 10 yr.

Mitral insufficiency ?

Senile Dementia 4-5- mo.

Due to

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

Duration

PHYSICIAN

Major findings:  
Of operations

Of autopsy

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 12/12/44

23. By Charles H. Werner M. D. or other M. D.  
Address Social Welfare Board Date signed 12/12/44

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 *Mollie E. Sidenfaden*

Licensed Embalmer, No. *4235*

P. O. Address *St. Joseph 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.**

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. Jan  
Registrar's No. 4235

Registration District No. 42 Primary Registration District No. 1000

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:  
(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

James A. Bond

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

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced W  
6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased April 24 (Month) (Day) (Year)

8. AGE: Years 85 Months 7 Days \_\_\_\_\_ If less than one day \_\_\_\_\_ min.

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

10. Usual occupation Retired  
11. Industry or business Saloon (formerly)

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) \_\_\_\_\_ (Burial, cremation, or removal) (b) Date thereof \_\_\_\_\_ (Month) (Day) (Year)  
(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_  
(b) Address \_\_\_\_\_  
19. (a) 1-12-75 (Date received local registrar) (b) Robert J. Palle (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

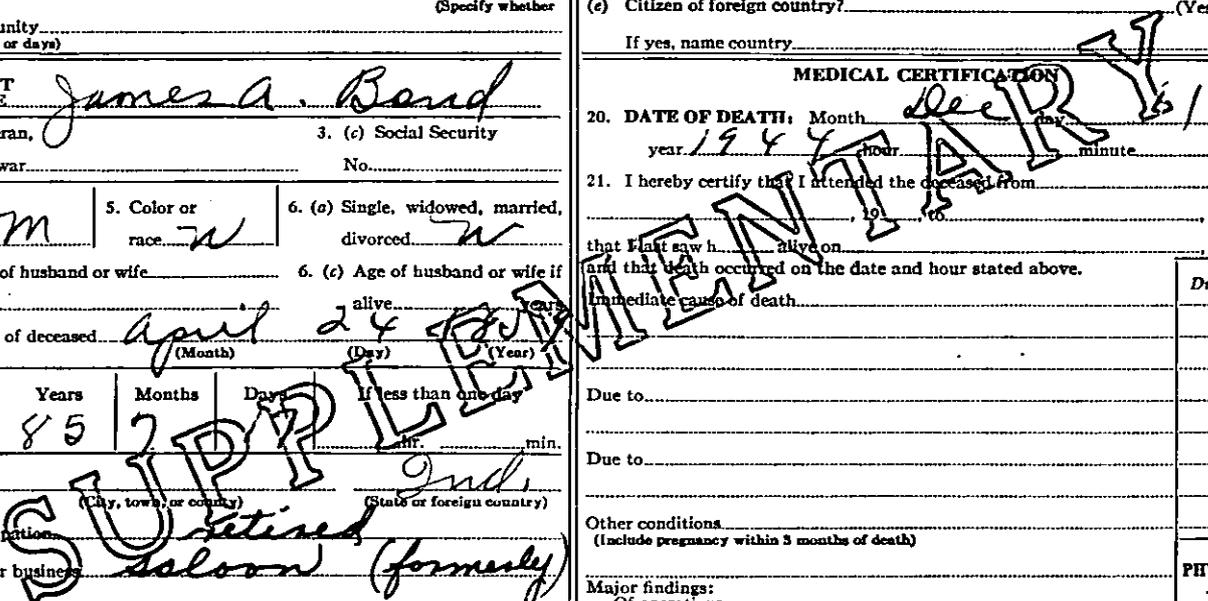
20. DATE OF DEATH: Month December Day 16 Year 1944 Hour \_\_\_\_\_ Minute \_\_\_\_\_ M.  
21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_ to \_\_\_\_\_, 19\_\_\_\_; that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_; and that death occurred on the date and hour stated above. Immediate cause of death \_\_\_\_\_

Due to \_\_\_\_\_  
Due to \_\_\_\_\_  
Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_  
Major findings: Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_

Duration \_\_\_\_\_  
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



1944  
S-40628