

Registration District No. 318

Primary Registration District No. 1003

Registrar's No. 414

1. PLACE OF DEATH:

(a) County Missouri

(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: De Paul Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution Three weeks
(Specify whether)

In this community _____
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County _____

(c) City or town St. Louis
(If outside city or town limits, write "RURAL")

(d) Street No. 4905 Maffitt Pl.
(If rural, give location)

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

If yes, name country _____

3. (a) PRINT FULL NAME Florence A. Bonner

3. (b) If veteran, name war _____ 3. (c) Social Security No. 494-05-9258

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

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if _____

7. Birth date of deceased: November 7 1893
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>51</u>	<u>2</u>	<u>6</u>	hr. _____ min. _____

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

10. Usual occupation Clerk

11. Industry or business War Plant

MOTHER FATHER

12. Name Alex. Bonner

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

14. Maiden name Mary Scanlon

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

16. (a) Informant Laura Bonner

(b) Address 4905 Maffitt Pl.

17. (a) Burial (b) Date thereof 1/16/45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Calvary Cemetery

18. (a) Signature of funeral director Mark Terson

(b) Address 6700 W. Florissant

19. (a) JAN 15 1945 (b) J. F. Budeck (c) _____
(Date received local health officer's report) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan. day 13th
year 1945 hour 1 minute 20 A.M.

21. I hereby certify that I attended the deceased from 12-18-44, 19____, to 1-13-45, 19____; that I last saw her alive on 1-12-45, 19____; and that death occurred on the date and hour stated above.

Immediate cause of death Rheumatic heart disease
Duration don't know

Due to Cerebral embolus
12-18-44

Due to _____

Other conditions 95
(Include pregnancy within 3 months of death)

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 _____

Address 1506 St. Louis (M. D. or other) _____

Date signed _____

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

Mark Lerman

Licensed Embalmer No. *4174*

P. O. Address. *6100 W. Florissant*

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.