

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 968
Registrar's No. 207

FILED FEB 6 1945

Registration District No. _____

Primary Registration District No. 1002

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

1. PLACE OF DEATH:

(a) County Jackson

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

(c) Name of hospital or institution:
2839 E 9th St
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____
In this community 30 years / (Specify whether years, months or days)

3. (a) PRINT FULL NAME Mrs Ignazio Giuseppe Bonanti

3. (b) If veteran, name war _____ No. _____

3. (c) Social Security No. _____

4. Sex Female / 5. Color or race White

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

6. (b) Name of husband or wife unR

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

7. Birth date of deceased 1874
(Month) (Day) (Year)

8. AGE: Years 70 Months _____ Days _____
If less than one day _____ hr. _____ min.

9. Birthplace Italy 5
(City, town, or county) (State or foreign country)

10. Usual occupation House Wife

MOTHER FATHER

11. Industry or business _____

12. Name Micheal Amore

13. Birthplace Italy 5
(City, town, or county) (State or foreign country)

14. Maiden name Venanzina Ferraro

15. Birthplace Italy 5
(City, town, or county) (State or foreign country)

16. (a) Informant Franco Bonanti

(b) Address 2839 E 9th St

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 17 1945
(Month) (Day) (Year)

(c) Place: burial or cremation St. Marys

18. (a) Signature of funeral director Pennino Bros

(b) Address Kennett City Mo

19. (a) 1-15-45 (Date received local registrar) (b) T. E. Brown (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Jackson 48

(c) City or town Kennett City Mo 3
(If outside city or town limits, write "RURAL")

(d) Street No. 2839 E 9th St 8
(If rural, give location)

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 13 year 1945 hour 6:30 minute A M.

21. I hereby certify that I attended the deceased from Jan 1 - 2 11 AM 1945, to Jan 13 1945 that I last saw her alive on Jan 13 1945 and that death occurred on the date and hour stated above.

Immediate cause of death Coronary occlusion

Due to arterio sclerosis - Sudden

Due to Coronary sclerosis

Other conditions (Include pregnancy within 3 months of death) no

Major findings: Of operations _____

Of autopsy no

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 A. Gladino (M.D. or other) _____
Address 421 Buells Date signed 1/15/45

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.....

Francis Walter

Licensed Embalmer No.....

2744

P. O. Address.....

12 C no.

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.