

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 14067
3142

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. _____

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Illinois b. COUNTY Madison	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Venice	
c. LENGTH OF STAY (in this place) 9 days		d. STREET ADDRESS (If rural, give location) 1005 Market	
d. FULL NAME OF HOSPITAL OR INSTITUTION Peoples Hospital			

3. NAME OF DECEASED (Type or Print)	a. (First) WALTER	b. (Middle)	c. (Last) BONNER	4. DATE OF DEATH (Month) (Day) (Year)	April 1, 1952
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5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED, Married	8. DATE OF BIRTH Feb 7, 1895	9. AGE (In years last birthday) 57	IF UNDER 1 YEAR Months	IF UNDER 12 HRS. Hours	IF UNDER 1 MIN. Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Chainer	10b. KIND OF BUSINESS OR INDUSTRY Steel Foundry	11. BIRTHPLACE (State or foreign country) Paris, Texas	12. CITIZEN OF WHAT COUNTRY? USA
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13a. FATHER'S NAME Unknown	13b. MOTHER'S MAIDEN NAME Unknown	14. NAME OF HUSBAND OR WIFE Leona Bonner
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	16. SOCIAL SECURITY NO. 328-07-2633	17. INFORMANT'S SIGNATURE OR NAME Leona Bonner 1005 Market, Venice, Ill.	ADDRESS
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH 2 mos.
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Hypertensive Cardin - Vascular Dis		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? H43X
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22. I hereby certify that I attended the deceased from 2/26, 1952, to 4/1, 1952, that I last saw the deceased alive on 4/1, 1952, and that death occurred at 6:15 p.m., from the causes and on the date stated above.

23a. SIGNATURE Ed Wood M.D.	(Degree or title)	23b. ADDRESS 4448 E. Easton	23c. DATE SIGNED 4/2/52
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24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	24b. DATE April 3, 1952	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State) East St. Louis, Illinois
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DATE REC'D BY LOCAL APR 3 1952	REGISTRAR'S SIGNATURE J. Carl Smith M.D.	25. FUNERAL DIRECTOR'S SIGNATURE Marshall Funeral Home - East St. Louis, Ill	ADDRESS
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(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING 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 _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed *Thomas M. Dubson*

Licensed Embalmer No. 4479

2205 Missouri Ave.

P. O. Address East St. Louis, Ill.

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.