

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-027877
STATE FILE NUMBER

9
FILED JUL 21 1958

Registration District No. 324

Primary Registration District No. 6093

Registrar's No. 115

97.2
S. 300
1-57

1. PLACE OF DEATH a. COUNTY Saline			2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Mo. b. COUNTY Saline		
b. CITY OR TOWN Marshall		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	c. CITY OR TOWN Marshall		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF HOSPITAL OR INSTITUTION County Home		Length of stay in lb	d. STREET ADDRESS R. F. D.		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Burb Middle M. Last Bonar			4. DATE OF DEATH Month July- Day 13- Year 1958		
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11/7/1874	9. AGE (In years last birthday) 73	IF UNDER 1 YEAR Months 8 Days
10a. USUAL OCCUPATION (Give kind of work done during most of year) retired farmer	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) Layfette Co. Mo.		12. CITIZEN OF WHAT COUNTRY? U S	
13a. FATHER'S NAME don't know		13b. MOTHER'S MAIDEN NAME Abraham Bonar don't know		14. NAME OF HUSBAND OR WIFE none	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. no	17. INFORMANT Forest Bonar, R.F.D. Slater, Mo.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Paresis					INTERVAL BETWEEN ONSET AND DEATH 6 months
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) _____ DUE TO (c) _____					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)			
20c. TIME OF INJURY Hour _____ a.m. _____ p.m.					
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> WORK <input type="checkbox"/> NOT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION		COUNTY	STATE
21. I attended the deceased from Jan. 1958 to July 12 and last saw her alive on July 11 - 1958 Death occurred at 9:45 p.m. on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE P. L. Lawless M.D.			22b. ADDRESS Marshall		22c. DATE SIGNED 7-16-58
23a. BURIAL, CREMATION, etc. (Specify) Buried	23b. DATE 7/16/58	23c. NAME OF CEMETERY OR CREMATORY City Cemetery,		23d. LOCATION (City, town, or county) Slater, Mo.	(State)
24. FUNERAL DIRECTOR Hill Brothers - Slater Mo.		ADDRESS	25. DATE RECD. BY LOCAL REG. 7-16-58	26. REGISTRAR'S SIGNATURE Paul A. Reed	

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION

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 me, Student Embalmer No. working under my personal supervision.

Student
Signature of Student Embalmer

Signed Sam M. Hill

Licensed Embalmer No. 1292
P. O. Address State, N

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.