

**RIDIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**  
**FILED VS AUG 12 1959**

**59-024356**

STATE FILE NUMBER

Registration District No. 47 Primary Registration District No. 3008 Registrar's No. 208

DED

1. PLACE OF DEATH a. COUNTY <u>Callaway</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> COUNTY <u>Callaway</u>					
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Fulton</u>		Length of stay in 1b <u>5 1/2 Weeks</u>		c. CITY OR TOWN <u>Fulton</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Callaway Hospital</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>207 West 4th St.</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>Burt</u> Last <u>Bonard</u>				4. DATE OF DEATH Month <u>Aug.</u> Day <u>6</u> Year <u>1959</u>					
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <u>1-2-1891</u>	9. AGE (last birthday) <u>68</u>	IF UNDER 1 YEAR Months <u>    </u> Days <u>    </u>	IF UNDER 24 HR Hours <u>    </u> Min. <u>    </u>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Manager, Pool and Billiard Parlor</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Billiard Parlor</u>		11. BIRTHPLACE (City and state or country) <u>Fulton, Missouri</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>		
13a. FATHER'S NAME <u>John Bonard</u>			13b. MOTHER'S MAIDEN NAME <u>Mary C. Oestreich</u>			14. NAME OF HUSBAND OR WIFE <u>Christena Margaret</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>			16. SOCIAL SECURITY NO. <u>497-03-2204</u>		17. INFORMANT Address <u>Mrs. Wm. B. Bonard Fulton, Mo</u>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma Pancreas</u> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH <u>1 yr.</u>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)						PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown			
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.		Month, Day, Year _____							
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT 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 <u>1950</u> to <u>Death</u> and last saw her <u>alive</u> on <u>8-6-59</u> Death occurred at <u>2:45</u> m on the date stated above, and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE (Degree or title) <u>John Brown MD</u>				22b. ADDRESS <u>Fulton, Mo</u>				22c. DATE SIGNED <u>8-8-59</u>	
23a. BURIAL - CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>Aug-9-1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Callaway Memorial Gardens</u>			23d. LOCATION (City, Town, or county) <u>Fulton</u>		(State) <u>Mo</u>	
24. FUNERAL DIRECTOR <u>Halleck Funeral Home, Fulton, Mo</u>			ADDRESS		25. DATE RECD. BY LOCAL REG. <u>August 8, 1959</u>		26. REGISTRAR'S SIGNATURE <u>Maretha Lawrence</u>		

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by \_\_\_\_\_  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed *A. P. Masure*

Licensed Embalmer No. 4996

P. O. Address Fulton, 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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.