

# DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

# =60-022816

FILED VS JUN 27 1960/28

Registration District No. \_\_\_\_\_ Primary Registration District No. 2000 Registrar's No. 688

STATE FILE NUMBER

|   |  |   |   |   |  |  |  |  |  |  |  |  |  |
|---|--|---|---|---|--|--|--|--|--|--|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Greene</b>  |  |   |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Missouri</b> b. COUNTY <b>Greene</b> |  |  |  |  |  |  |  |  |  |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR TOWN <b>Springfield</b>   |  | Length of stay in 1b<br><b>1 day</b>  |   | c. CITY OR TOWN <b>Strafford</b>  |  | Inside Limits<br>Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>   |  |  |  |  |  |  |  |
| c. FULL NAME OF (If NOT in hospital, give location)<br>HOSPITAL OR INSTITUTION <b>Doctor's Memorial Hosp.</b>   |  |   | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>                      |   | d. STREET ADDRESS (If outside, give location)<br><b>no street number</b> |  | Reside on Farm<br>Yes <input type="checkbox"/> No <input type="checkbox"/> |  |  |  |  |  |  |
| 3. NAME OF DECEASED<br>(Type or print)<br>First <b>CORA</b> Middle <b>CAROLINE</b> Last <b>BONNER</b>   |  |   |   | 4. DATE OF DEATH<br>Month <b>JUNE</b> Day <b>19</b> Year <b>1960</b>  |  |  |  |  |  |  |  |  |  |
| 5. SEX<br><b>Female</b>   | 6. COLOR OR RACE<br><b>White</b>       | 7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/><br>Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> |   | 8. DATE OF BIRTH<br><b>6-11-1880</b>  | 9. AGE (last birthday)<br><b>80</b>                                      | IF UNDER 1 YEAR<br>Months _____ Days _____   |  | IF UNDER 24 HR<br>Hours _____ Min. _____ |  |  |  |  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b>   |  |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Home</b>  |   | 11. BIRTHPLACE (City and state or country)<br><b>Taney Co. Missouri</b>  |  | 12. CITIZEN OF WHAT COUNTRY<br><b>USA</b>                                  |  |  |  |  |  |  |
| 13a. FATHER'S NAME<br><b>Charlie Young</b>  |  |   | 13b. MOTHER'S MAIDEN NAME<br><b>Mary Taneyhill</b>  |   |  | 14. NAME OF HUSBAND OR WIFE<br><b>Mr T.B. Bonner</b>   |  |  |  |  |  |  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no or unknown) (If yes, give war or dates of service)<br><b>NO</b>   |  |   | 16. SOCIAL SECURITY NO.<br><b>None</b>  |   | 17. INFORMANT<br>Address<br><b>Mr T.B. Bonner, Strafford Mo.</b>         |  |  |  |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Respiratory Failure</b>  |  |   |   |   |  |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>3 hrs</b>                           |  |  |  |  |  |  |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <b>Cerebral Hemorrhage</b>  |  |   |   |   |  |  | <b>17 hrs</b>  |  |  |  |  |  |  |
| DUE TO (c) <b>Hypertension ( unknown)</b>   |  |   |   |   |  |  |  |  |  |  |  |  |  |
| 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.<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown |  |  |  |  |  |  |  |
| 19. WAS AUTOPSY PERFORMED?<br>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<br>Hour _____ a.m. _____ p.m.<br>Month, Day, Year _____   |  |   | 20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/><br>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<br>COUNTY _____ STATE _____ |  |
| 21. I attended the deceased from <b>6-18-60</b> , to <b>6-19-60</b> and last saw her alive on <b>6-19-60</b><br>Death occurred at <b>11:15 A</b> _____ m on the date stated above, and to the best of my knowledge, from the causes stated. |  |   |   |   |  |  |  |  |  |  |  |  |  |
| 22a. SIGNATURE<br><i>D. Andrew Martinich D.O.</i> (Degree or title)   |  |   |   | 22b. ADDRESS<br><b>Springfield, Missouri</b>  |  |  |  | 22c. DATE SIGNED<br><b>6-22-60</b>       |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |  | 23b. DATE<br><b>6-21-60</b>   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>HOPEDALE CEMETERY</b>  |   |  | 23d. LOCATION (City, town, or county)<br><b>CHRISTIAN CO MO</b>  |  |  |  |  |  |  |  |
| 24. FUNERAL DIRECTOR<br><b>Rex Rainey, Springfield, Mo</b>  |  |   | 25. DATE RECD. BY LOCAL REG.<br><b>6-23-60</b>  |   | 26. REGISTRAR'S SIGNATURE<br><i>Effie S. Meeton</i>                      |  |  |  |  |  |  |  |  |

(Licensed Embalmer's Statement on Reverse Side)

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  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

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

Signed *Rex James*

Licensed Embalmer No. 3

P. O. Address Spring

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure 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.