

# CERTIFICATE OF HEALTH - STANDARD CERTIFICATE OF DEATH

9 1961 Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 12149 -60-047313  
STATE FILE NUMBER

<b>1. PLACE OF DEATH</b> a. COUNTY _____  b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Louis, Missouri</u> Length of stay in 1b <u>5 WEEKS</u>		<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>ILLINOIS</u> b. COUNTY <u>MADISON</u>  c. CITY OR TOWN <u>COLLINSVILLE</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> d. STREET ADDRESS (If outside, give location) <u>500 RIDGEMONT</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) First <u>CARMEL</u> Middle <u>MARY</u> Last <u>BONEAU</u>		<b>4. DATE OF DEATH</b> Month <u>DECEMBER</u> Day <u>17</u> Year <u>1960</u>	

<b>5. SEX</b> <u>FEMALE</u>	<b>6. COLOR OR RACE</b> <u>WHITE</u>	<b>7. Married</b> <input checked="" type="checkbox"/> <b>Never Married</b> <input type="checkbox"/> <b>Widowed</b> <input type="checkbox"/> <b>Divorced</b> <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>11/16/12</u>	<b>9. AGE (last birthday)</b> <u>48</u>	<b>IF UNDER 1 YEAR</b> Months _____ Days _____ <b>IF UNDER 24 HR</b> Hours _____ Min. _____
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>AT HOME</u>		<b>11. BIRTHPLACE</b> (City and state or country) <u>COLLINSVILLE, ILL</u>	
<b>13a. FATHER'S NAME</b> <u>FRANK ZINKE</u>		<b>13b. MOTHER'S MAIDEN NAME</b> <u>THERESA CIANO</u>		<b>14. NAME OF HUSBAND OR WIFE</b> <u>ROBERT W. BONEAU</u>	

<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>	<b>16. SOCIAL SECURITY NO.</b> <u>357-10-8034</u>	<b>17. INFORMANT</b> <u>ROBERT W. BONEAU</u> Address _____
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<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic carcinoma of the breasts to the lungs.</u> DUE TO (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>abt. 2 yrs.</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		<u>170x</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 checked="" type="checkbox"/> No <input type="checkbox"/> Unknown

<b>19. WAS AUTOPSY PERFORMED?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	<b>20a. ACCIDENT</b> <input type="checkbox"/> <b>SUICIDE</b> <input type="checkbox"/> <b>HOMICIDE</b> <input type="checkbox"/>	<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in PART I or PART II of item 18.)
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<b>20c. TIME OF INJURY</b> Hour _____ a.m. _____ p.m. Month, Day, Year _____	<b>20d. INJURY OCCURRED WHILE AT WORK</b> <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	<b>20e. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)	<b>20f. CITY, TOWN, OR LOCATION</b> COUNTY STATE
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**21.** I attended the deceased from 6/12/59 to 12/17/60 and last saw <sup>her</sup> ~~she~~ alive on 12/17/60  
 Death occurred at 6:45 p.m. on the date stated above, and to the best of my knowledge, from the causes stated.

<b>22a. SIGNATURE</b> (Degree or title) <u>F.R. Bradley, M.D.</u>	<b>22b. ADDRESS</b> <u>BARNES HOSPITAL</u>	<b>22c. DATE SIGNED</b> <u>12/18/60</u>
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<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>REMOVAL</u>	<b>23b. DATE</b> <u>12/21/60</u>	<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>CATHOLIC CEMETERY</u>	<b>23d. LOCATION</b> (City, town, or county) (State) <u>COLLINSVILLE, ILLINOIS</u>
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<b>24. FUNERAL DIRECTOR</b> ADDRESS <u>HEBB FUNERAL HOME COLLINSVILLE, ILL</u>	<b>25. DATE RECD. BY LOCAL REG.</b> <u>DEC 19 1960</u>	<b>26. REGISTRAR'S SIGNATURE</b> <u>Carl Smith, M.D.</u>
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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 *Grace Howard*

Licensed Embalmer No. 3577

P. O. Address Collinsville

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.