MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

PLACE OF DEATH

County Howell

Township _____ or Village _____ or City West Plains Mo (NO. _____ St.; _____ Ward)

Registration District No. 384 File No. 37501

Primary Registration District No. 4227 Registered No. 78

[If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME Joseph Warren Benton

PERSONAL AND STATISTICAL PARTICULARS

SEX Male | COLOR OR RACE White | ~~SINGLE~~ MARRIED ~~WIDOWED~~ ~~OR DIVORCED~~ Married (Write the word)

DATE OF BIRTH Dec 1st (Month) (Day), 1833 (Year)

AGE 82 yrs. 11 mos. 9 ds. If LESS than 1 day, ___ hrs. or ___ min.?

OCCUPATION
(a) Trade, profession, or particular kind of work Retired Contractor
(b) General nature of industry, business, or establishment in which employed (or employer) Builder

BIRTHPLACE (City or town, State or foreign country) Henry Co Tenn

PARENTS
NAME OF FATHER Isaac Benton
BIRTHPLACE OF FATHER (City or town, State or foreign country) Dont Know
MAIDEN NAME OF MOTHER Dont Know
BIRTHPLACE OF MOTHER (City or town, State or foreign country) Dont Know

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs J. W. Benton
(ADDRESS) West Plains Mo

Filed 11-25-1916 O P Heinrich REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Nov 10th (Month) (Day), 1916 (Year)

I HEREBY CERTIFY, that I attended deceased from Aug 23, 1916, to Nov. 10, 1916, that I last saw him alive on Nov. 10, 1916, and that death occurred, on the date stated above, at 7 P.m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

9513
77 81

(Duration) 2 yrs. ___ mos. ___ ds.

Contributory (SECONDARY) Cardiac asthma

(Duration) ___ yrs. 2 mos. 17 ds.

(Signed) H. C. Shuttee M. D.
Nov. 25, 1916 (Address) West Plains Mo

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)
At place of death ___ yrs. ___ mos. ___ ds. In the State ___ yrs. ___ mos. ___ ds.
Where was disease contracted if not at place of death? _____
Former or usual residence _____

PLACE OF BURIAL OR REMOVAL Oak Lawn | DATE OF BURIAL Nov 12, 1916

UNDERTAKER McFarland Und Co | ADDRESS West Plains Mo

Revised United States Standard

MISSOURI STATE BOARD OF HEAL
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

PLACE OF DEATH

County _____

Township _____ Registration District No. _____ File No. _____

or

Village _____ Primary Registration District No. _____ Registered No. _____

or

City _____ (NO. _____ _____ St.; _____ Ward)

[If death occurre hospital or insti give its NAME i of street and numb

FULL NAME _____

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	SINGLE MARRIED WIDOWED OR DIVORCED (*Write* the word)

DATE OF BIRTH _____ (Month) _____ (Day) _____, 1_____ (Year)

AGE _____ yrs. _____ mos. _____ ds. If LESS than 1 day, _____ hrs. or _____ min.?

OCCUPATION
(a) Trade, profession, or particular kind of work _____

(b) General nature of industry, business, or establishment in which employed (or employer) _____

BIRTHPLACE (City or town, State or foreign country)

PARENTS

NAME OF FATHER

BIRTHPLACE OF FATHER (City or town, State or foreign country)

MAIDEN NAME OF MOTHER

BIRTHPLACE OF MOTHER (City or town, State or foreign country)

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) _____

(ADDRESS) _____

Filed _____, 191___, _____ REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH _____ (Month) _____ (Day) _____, 19 (Y

I HEREBY CERTIFY, that I attended deceased _____, 191___, to _____, 19

that I last saw h_____ alive on _____, 19

and that death occurred, on the date stated above, at _____

The CAUSE OF DEATH* was as follows:

_____

_____

_____ (Duration) _____ yrs. _____ mos. _____

Contributory (SECONDARY) _____

_____ (Duration) _____ yrs. _____ mos. _____

(Signed) _____ M

_____, 191___ (Address) _____

*State the Disease Causing Death, or, in deaths from Violent Causes, (1) Means of Injury: and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS RECENT RESIDENTS)

At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____

Where was disease contracted if not at place of death? _____

Former or usual residence _____

PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL _____, 191
UNDERTAKER	ADDRESS-