LOCAL REGISTRAR'S RECORD—DO NOT TEAR LEAF OUT

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

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

1 PLACE OF DEATH

County Stone

Township ~~Pierce~~ Registration District No. 842 File No. 38406

or Village Primary Registration District No. 4512 Registered No.

or City Crane (NO. St.; Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Tadd W Bennegl

PERSONAL AND STATISTICAL PARTICULARS	MEDICAL CERTIFICATE OF DEATH
3 SEX: male; 4 COLOR OR RACE: white; 5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): married	16 DATE OF DEATH: Dec (Month) 21 (Day), 1919 (Year)
6 DATE OF BIRTH: May (Month) 30 (Day), 1865 (Year)	17 I HEREBY CERTIFY, that I attended deceased from Dec 16, 1919, to Dec 21, 1919, that I last saw him alive on Dec 21, 1919, and that death occurred, on the date stated above, at 4 a.m.
7 AGE: 54 yrs. 6 mos. 22 ds. If LESS than 1 day, ...hrs. or ....min.?	The CAUSE OF DEATH* was as follows: Prostatic abscess Bursarand ruptured into Peritoneal cavity (Duration) ....yrs. ....mos. 6 ds.
8 OCCUPATION (a) Trade, profession, or particular kind of work: Farmer 35 / 137; (b) General nature of industry business, or establishment in which employed (or employer)	CONTRIBUTORY (Secondary): gonorrheal infection 30 years history (Duration) 30 yrs. ....mos. ....ds.
9 BIRTHPLACE (City or town, State or foreign country): Crawfordsville Ind	(Signed) B W Sweeney M. D. 12-22, 1919 (Address) Crane Mo
PARENTS: 10 NAME OF FATHER: Simon W Bennegl	*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.
11 BIRTHPLACE OF FATHER (City or town, State or foreign country): Ohio	18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents) At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.
12 MAIDEN NAME OF MOTHER: Maryann Sape	Where was disease contracted if not at place of death?
13 BIRTHPLACE OF MOTHER (City or town, State or foreign country): Ohio	Former or usual residence
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) Mrs T W Bennegl (Address) Marionville Mo	19 PLACE OF BURIAL OR REMOVAL: Marionville Mo; DATE OF BURIAL: 12-22, 1919
15 Filed Dec 24 1919 R W Kelly Registrar	20 UNDERTAKER: W E Hilton; ADDRESS: Crane Mo

LOCAL REGISTRAR'S RECORD—DO NOT TEAR LEAF OUT

1 PLACE OF DEATH

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

County .....

Township..... Registration District No..... File No.....
or
Village ..... Primary Registration District No. ..... Registered No. .....
or
City..... (NO....., ...St.;.....Ward)

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

2 FULL NAME.....

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE, MARRIED, WIDOWED OR DIVORCED (*Write* the word)

6 DATE OF BIRTH

..... (Month) ....., 1..... (Day) (Year)

7 AGE

.....yrs.....mos.....ds.

If LESS than 1 day,.....hrs. or.....min.?

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

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

9 BIRTHPLACE
(City or town, State or foreign country)

PARENTS

10 NAME OF FATHER

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

12 MAIDEN NAME OF MOTHER

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

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) .....

(Address).....

15

Filed....., 191....., ...
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

..... (Month) ....., 191..... (Day) (Year)

17 I HEREBY CERTIFY, that I attended deceased from

....., 191....., to....., 191.....

that I last saw h.....alive on....., 191.....,

and that death occurred, on the date stated above, at.....m.

The CAUSE OF DEATH* was as follows:

.....

.....

.....

..... (Duration).....yrs.....mos.....ds.

CONTRIBUTORY .....
(Secondary)

..... (Duration).....yrs.....mos.....ds.

(Signed).....M. D.

....., 191..... (Address).....

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

18 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.....

19 PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL ....., 191.....
20 UNDERTAKER	ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.