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

Do not use this space.

23 1929

11
6
9

1. PLACE OF DEATH

County Buchanan. Registration District No. 85 File No. 9569

Township Primary Registration District No. 1001 Registered No. 300

City St. Joseph (No. 2616 Patee Street. St. Ward)

2. FULL NAME Benjamin F. Showers

(a) Residence. No. 2616 Patee Street St., Ward. (If nonresident, give city or town and State)
(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word)
Male	White	Married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Minnie Showers

6. DATE OF BIRTH (MONTH, DAY AND YEAR) February 21, 1858

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, hrs. or min.
	71	0	14	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Retired Salesman

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

(c) Name of employer

172

9. BIRTHPLACE (CITY OR TOWN) Mechanicsburg
(STATE OR COUNTRY) Penn.

2

PARENTS

10. NAME OF FATHER John Showers

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Unknown
(STATE OR COUNTRY) Unknown

31

12. MAIDEN NAME OF MOTHER Moriah Hicks

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Unknown
(STATE OR COUNTRY) Unknown

31

14. INFORMANT Minnie Showers
(Address) 2616 Patee Street.

15. FILED MAR 6, 1929 John G. Jutz REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) March 5 1929

17. I HEREBY CERTIFY, That I attended deceased from Jan 4, 1929 to Mar 5, 1929 that I last saw him alive on Feb 25, 1929 and that death occurred, on the date stated above, at 11 A m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Sarcoma of left shoulder

about (duration) 2 yrs. mos. ds.

CONTRIBUTORY (SECONDARY) (duration) yrs. mos. ds.

49

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH

0 DID AN OPERATION PRECEDE DEATH? No DATE OF

WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS? Clinical & X Ray

(Signed) S. D. Fenor, M. D.

March 5 1929 (Address) Rock Island Bldg. St Joseph Mo

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) Whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Mt. Olivet Cemetery

DATE OF BURIAL 3-7 1929

20. UNDERTAKER H. O. Sidenfaden

ADDRESS 1802 Union St.

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.