

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

Do not use this space.

14 528-A

1. PLACE OF DEATH

County Jackson Registration District No. 396
Township St. George Primary Registration District No. 5352
City (No.) St. Ward)

File No.
Registered No. 5

2. FULL NAME

Wm Franklin Benson

(a) Residence. No. St. Ward.
(Usual place of abode)

Length of residence in city or town where death occurred 24 yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX m 4. COLOR OR RACE wh 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) m

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Viola Benson

6. DATE OF BIRTH (MONTH, DAY AND YEAR) mch 20 1856

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
73 1 4

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work... Retired Farmer
(b) General nature of industry, business, or establishment in which employed (or employer).....
(c) Name of employer.....

9. BIRTHPLACE (CITY OR TOWN) Knox County
(STATE OR COUNTRY) Ill.

10. NAME OF FATHER Henry Morgan Benson

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Sanguamon County, Ill.
(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER Virginia Pettigrew

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

14. INFORMANT Mrs Viola Benson
(Address) Sibley mo.

15. FILED 19..... REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) April 24 1929

17. I HEREBY CERTIFY, That I attended deceased from April 22, 1929, to April 24, 1929, that I last saw him alive on April 24, 1929, and that death occurred, on the date stated above, at 1 p. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Cerebral hemorrhage

CONTRIBUTORY (SECONDARY)

74

18. WHERE WAS DISEASE CONTRACTED:

IF NOT AT PLACE OF DEATH.....

DID AN OPERATION PRECEDE DEATH?..... DATE OF.....

WAS THERE AN AUTOPSY? m

WHAT TEST CONFIRMED DIAGNOSIS Clinical
(Signed) N. W. Hammond M. D.

5-10 1929 (Address) Buckner 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

Sibley Conn

DATE OF BURIAL

April 26
Sibley 29

20. UNDERTAKER

Wm Rappert

ADDRESS

Buckner

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

THIS IS AT

1950

STATE OF NEW YORK
IN SENATE
January 10, 1950

REPORT

OF THE

COMMISSIONERS OF THE DEPARTMENT OF SOCIAL SERVICES

IN RESPONSE TO A RESOLUTION PASSED BY THE SENATE

ON APRIL 11, 1949

RELATIVE TO THE

ADMINISTRATION OF THE DEPARTMENT OF SOCIAL SERVICES

FOR THE YEAR 1949

ALBANY: THE UNIVERSITY OF THE STATE OF NEW YORK PRESS, 1950

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

ALL INFORMATION CALLED
FOR MUST BE WRITTEN ON
THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County Jackson Registration District No. 396 File No.
Township J. L. Osage Primary Registration District No. 3552 Registered No. 3
City (No.) St. Ward)

2. FULL NAME Wm Franklin Benson

(a) Residence. No. St. Ward.
(Usual place of abode) (If nonresident, give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>M</u>	4. COLOR OR RACE <u>W</u>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <u>M</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF		
6. DATE OF BIRTH (MONTH, DAY AND YEAR)		
7. AGE YEARS	MONTHS	DAYS
If LESS than 1 day, hrs. or min.		
8. OCCUPATION OF DECEASED		
(a) Trade, profession, or particular kind of work		
(b) General nature of industry, business, or establishment in which employed (or employer)		
(c) Name of employer		

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

PARENTS

10. NAME OF FATHER
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY)
12. MAIDEN NAME OF MOTHER
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY)

14. INFORMANT (Address)

15. FILED May 10, 19 29 N. D. Ramsdorf REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) April 24 1929

17. I HEREBY CERTIFY That I attended deceased from to 19....., that I last saw h..... alive on....., 19....., and that death occurred, on the date stated above, at..... n.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

..... (duration) yrs. mos. ds.

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

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH.....

DID AN OPERATION PRECEDE DEATH?..... DATE OF.....

WAS THERE AN AUTOPSY?

WHAT TEST CONFIRMED DIAGNOSIS?

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

, 19..... (Address)

*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	DATE OF BURIAL
20. UNDERTAKER	ADDRESS

SUPPLEMENTARY

WRITE PENCIL WITH UNFADING INK--THIS IS A PERMANENT RECORD

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF every item of death terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

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