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EP 25 1929
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MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Do not use this space.

28217

1. PLACE OF DEATH
County Laclede
Township
City Lebanon Mo (No. ..... St. ..... Ward)

Registration District No. 449
Primary Registration District No. 4267

File No.
Registered No. 1517

2. FULL NAME Sarah L Benton

(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 F
4. COLOR OR RACE W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Widow

5A. IF MARRIED, WIDOWED, OR DIVORCED ~~HUSBAND OF~~ ~~(or)~~ WIFE OF A. C. Benton

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Apr 15 1852

7. AGE

YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
77	3	19	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work House Wife
(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) Knox Co Tenn

PARENTS

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

14. INFORMANT Best Benton
(Address) Lebanon Mo

15. FILED 8/5, 1929 J M Billings REGISTRAR

2 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Aug - 4 1929

17. I HEREBY CERTIFY, That I attended deceased from July 26, 1929, to Aug 5 1929, that I last saw her alive on Aug 2 1929, and that death occurred, on the date stated above, at 12 30 a m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Mitral Regurgitation
92A
162
90A
(duration) 10 yrs. ..... mos. ..... ds.

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

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH? ✓
DID AN OPERATION PRECEDE DEATH? no DATE OF .....
WAS THERE AN AUTOPSY? no
WHAT TEST CONFIRMED DIAGNOSIS? Phys Exam
(Signed) J. H. Casey, M. D
, 19 (Address) Lebanon 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 Lonesomehill Cemetery
DATE OF BURIAL Aug 5 1929

20. UNDERTAKER Holman & Stewart
ADDRESS Lebanon Mo

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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.

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