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JAN 21 1930

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

Do not use this space.

1. PLACE OF DEATH
County Stoddard — Registration District No. 837 — File No. 39396
Township Castor — Primary Registration District No. 6099 — Registered No.
City ..... (No. ....., ... St. ..... Ward)

2. FULL NAME Samuel H 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	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word)
Mote	Whit	Single

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 6-1849

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
	80	4	25	

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

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

PARENTS

10. NAME OF FATHER John Benton
11. BIRTHPLACE OF FATHER (CITY OR TOWN) —
(STATE OR COUNTRY) 2
12. MAIDEN NAME OF MOTHER Wm J Crowl
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Dust Dunn
(STATE OR COUNTRY)

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14. INFORMANT Eli Becraft
(Address) Bloomfield Mo

15. FILED Jan 7, 1930 Edw. Ford
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Nov 25 1929

17. I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19....., that I last saw h..... alive on ....., 19....., and that death occurred, on the date stated above, at 3-30 A m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Senile Degeneration
162
164
(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) E A Brinegar, M. D.
, 19 (Address) Bloomfield 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	DATE OF BURIAL
Friglett Cem	11-26 1929

20. UNDERTAKER	ADDRESS
J. A. Childs	Bloomfield

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.