

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

Do not use this space.

13419  
8

**1. PLACE OF DEATH**

County New Madrid

Registration District No. 55

Township Anderson

Primary Registration District No. 4039

City Osion (No. ....)

File No. ....

Registered No. 851

St. .... Ward)

**2. FULL NAME**

Willedad Katherine Bennett

(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 7 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 M

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Nov 11 1892

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, ..... hrs. or ..... min.
	<u>37</u>	<u>5</u>	<u>5</u>	

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) MO

10. NAME OF FATHER Bob Jenkins

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

12. MAIDEN NAME OF MOTHER Am. Chaney

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

14. INFORMANT Sam Bennett (Address) Osion, MO

15. FILED May 10 1930 M. V. McManis REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) 4-16-1930

17. I HEREBY CERTIFY, That I attended deceased from 4-3-1930 to 4-18-1930, 1930, that I last saw her alive on 4-15-1930, and that death occurred, on the date stated above, at 5:30 P. m.

**THE CAUSE OF DEATH\* WAS AS FOLLOWS:**

Pulmonary T. B.  
NSA

CONTRIBUTORY (SECONDARY) SA (duration) 1 yrs. .... mos. .... ds.

18. WHERE WAS DISEASE CONTRACTED  
IF NOT AT PLACE OF DEATH .....

8 DID AN OPERATION PRECEDE DEATH? ..... DATE OF .....  
WAS THERE AN AUTOPSY? .....

WHAT TEST CONFIRMED DIAGNOSIS  
(Signed) J. B. Stemann, M. D.  
4-17-1930 (Address) Clarkton 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 Standfield Cem DATE OF BURIAL 4-18 1930

20. UNDERTAKER Walt Hunter ADDRESS Osion MO

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.

