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

Do not use this space.

22656

File No. .....
Registered No. 675

1. PLACE OF DEATH
County: Hall
Township: Liberty
City: ..... (No. ..... St. ..... Ward)
Registration District No. 372
Primary Registration District No. 5579

2. FULL NAME: Chas A. Benedict

(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: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): Single

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR): April 12 1862

7. AGE: Years 68 | Months 3 | Days 2 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Farm Laborer
(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.

PARENTS

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

14. INFORMANT: Mrs Russell Mann
(Address): Mound City Mo

15. FILED 7/15/30, 19..... J. C. Bracey, REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): 7/14/30, 19

17. I HEREBY CERTIFY, That I attended deceased from July 10, 1930, to July 14, 1930, 19 30, that I last saw him alive on July 13 1930, and that death occurred, on the date stated above, at 6 a.m. 3 p.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Carcinoma Stomach
41B
(duration) ..... yrs. 3 mos. ..... ds.

CONTRIBUTORY (SECONDARY) 4 4 0
(duration) ..... yrs. 7 mos. ..... ds.

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? Physical
(Signed) O. M. Everly, M. D
7/14, 1930 (Address) Mound City 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: New Liberty — DATE OF BURIAL: 7/15 1930

20. UNDERTAKER: W. H. Crawford — ADDRESS: Mound City 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 OCCUPATIONS is very important.

WRITE PLAINLY, WITH UNFADING INK. ALL ITEMS MUST BE ANSWERED.