

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

Do not use this space.

30058

1. PLACE OF DEATH

County Jackson
Township Kaw
City Kansas City, Mo (No. 5408 Brooklyn Ave.,)

Registration District No. 399
Primary Registration District No. 1008

File No. _____
Registered No. 3334
St. _____ Ward _____

2. FULL NAME Mrs. Josephine Benson

(a) Residence. No. 5408 Brooklyn Ave., St. 15 Ward.

(Usual place of abode) (If nonresident, give city or town and State)
Length of residence in city or town where death occurred 37 yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female	4. COLOR OR RACE white	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) widow
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5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR) April 26, 1863

7. AGE	YEARS 67	MONTHS 4	DAYS 24	IF LESS than 1 day, _____ hrs. or _____ min.
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8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. At home
(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) Sweden

10. NAME OF FATHER John L. Johnson

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

12. MAIDEN NAME OF MOTHER Louise Berguson

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

14. INFORMANT Lawrence A. Benson
(Address) 5408 Brooklyn

15. FILED 9/22/30 M. M. Brown REGISTRAR
West

2 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Sept. 20, 1930

17. I HEREBY CERTIFY, That I attended deceased from Sep 8, 1930, to Sep 20, 1930 that I last saw her alive on Sep 20, 1930 and that death occurred, on the date stated above, at 1:30 P. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Tumor Bladder
Papilloma not
independent
5475 (duration) _____ yrs. _____ mos. _____ ds.
CONTRIBUTORY (SECONDARY) Secondary anemia
(duration) _____ 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? no

WHAT TEST CONFIRMED DIAGNOSIS? Cystoscope
(Signed) Ward H. Gerard, M. D.
9/20, 1930 (Address) 3232 Sumner

*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 Elmwood Cemetery **DATE OF BURIAL** 9/22 1930

20. UNDERTAKER Freeman Mortuary, K.C.Mo **ADDRESS** Kc 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.

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