

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

Do not use this space.

14960

1. PLACE OF DEATH

County Miller
Township Galine
City (No. _____) _____ St. _____ Ward _____

Registration District No. 561
Primary Registration District No. 5755

File No. _____
Registered No. 50

2. FULL NAME

Clifford Leon Bentrup
(a) Residence, No. _____ St. _____ Ward _____
(Usual place of abode)
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. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED — (write the word)

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Sept. 2, 1939

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
11 7 20

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. 794

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. 123

10. Date deceased last worked at this occupation (month and year) _____ 11. Total time (years) spent in this occupation 5

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Little Rock Arkansas

13. NAME C. W. Bentrup

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Des Moines Iowa

15. MAIDEN NAME Lois Knabe

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Little Rock Arkansas

17. INFORMANT (ADDRESS) C. W. Bentrup Little Rock Arkansas

18. BURIAL, CREMATION OR REMOVAL PLACE Little Rock Ark DATE 4-22 1931

19. UNDERTAKER (ADDRESS) W. A. Phillips Eldon Mo

20. FILED 4-22 1931 Belle Haynes Registrar.

MEDICAL CERTIFICATE OF DEATH

3 21. DATE OF DEATH (MONTH, DAY, AND YEAR) April 22, 1931

22. I HEREBY CERTIFY, That I attended deceased from 4-15 1931, to 4-21 1931. I last saw him alive on 4-21 1931. Death is said to have occurred on the date stated above, at 4 A m.

The principal cause of death and related causes of importance were as follows:
Stomach ~~and~~ disorders
Intestinal disorder

Date of onset
Mar
26th
1931

Other contributory causes of importance:
Spinal meningitis

Name of physician _____ Date of _____
What best confirmed diagnosis? none Was there an autopsy? _____

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide _____ Date of injury _____, 19____

Where did injury occur? _____ (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury _____
Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased?
If so, specify _____

(Signed) L. W. Mathers D.C.
(Address) Eldon 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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CERTIFICATE OF DEATH**

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH.
 County Miller Registration District No. 361 File No. _____
 Township Dalmine Primary Registration District No. 1-453- Registered No. 30
 City _____ (No. _____) St. _____ Ward _____

2. FULL NAME Clifford Leon Bentrup
 (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

MEDICAL CERTIFICATE OF DEATH

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED S (write the word)
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____
 6. DATE OF BIRTH (MONTH, DAY AND YEAR) Sept 2 - 1929
 7. AGE: YEARS 19 MONTHS 7 DAYS 20 If LESS than 1 day, _____ hrs. or _____ min.
 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) _____
 10. NAME OF FATHER _____
 11. BIRTHPLACE OF FATHER (CITY OR TOWN) _____ (STATE OR COUNTRY) _____
 12. MAIDEN NAME OF MOTHER _____
 13. BIRTHPLACE OF MOTHER (CITY OR TOWN) _____ (STATE OR COUNTRY) _____
 14. INFORMANT _____ (Address) _____
 15. FILED 4-22-31 Belle Haynes REGISTRAR

16. DATE OF DEATH (MONTH, DAY AND YEAR) April 22 1931
 17. I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____, that I last saw him _____ after or _____, 19____, and that death occurred, on the date stated above, at _____ m.
 THE CAUSE OF DEATH* WAS AS FOLLOWS:

 _____ (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) _____, M. D.
 _____, 19____ (Address) _____
 *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 _____ 19____
 20. UNDERTAKER _____ ADDRESS _____

SUPPLEMENTARY

WRITE PLAINLY, WITH UNFADING INK. THIS IS A PERMANENT RECORD
 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. REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

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