

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

Do not use this space.

6615

791
1008

File No. _____
Registered No. **1689**
St. _____ Ward)

1. PLACE OF DEATH

County _____ Registration District No. _____
Township _____ Primary Registration District No. _____
City _____ No. **St Paul Hospital**

2. FULL NAME

Joseph Bennett
(a) Residence. No. **401 Greely Ave Webster Groves 6** Ward. **Webster Groves Mo**
(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) **Apr 30 1888**

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
	43	9	20	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work. **Electrician Theatrical**
(b) General nature of industry, business, or establishment in which employed (or employer). **32**
(c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) **Salem Ill** 2
(STATE OR COUNTRY)

10. NAME OF FATHER **Q A Bennett**

11. BIRTHPLACE OF FATHER (CITY OR TOWN) **Salem Ill**
(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER **Lara M Williams**

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

14. INFORMANT **Mrs Lara Bennett**
(Address) **Webster Groves**

15. FILED **21 1932** **Max C Stanley** REGISTERAR

No Physical MEDICAL CERTIFICATE OF DEATH *attendance*

16. DATE OF DEATH (MONTH, DAY AND YEAR) **Feb. 20th 1932**

17. I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____, and that I last saw him _____ alive on _____, 19____, and that death occurred, on the date stated above, at _____ m.

THE CAUSE OF DEATH* WAS AS FOLLOWS: **194 F. 312**

Septicemia following injury to left hand, received while changing a sign at Webster Groves, Mo. St. Louis, Mo.

CONTRIBUTORY (SECONDARY) **(43)** (duration) _____ yrs. _____ mos. _____ ds.

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

19. DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____
WAS THERE AN AUTOPSY? **Yes**

WHAT TEST CONFIRMED DIAGNOSIS
(Signed) **John G. Sturdivant, M.D.**

2. **122**. 1932 (Address) **200 W. Washington**
*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 **Salem Ill** DATE OF BURIAL **23 1932**

20. UNDERTAKER **A Ellis S neo Delman Blvd** ADDRESS

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.

