

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

JUL 22 1933

1. PLACE OF DEATH

County Schuyler
Township Wolf River
City Greentop (No.)

Registration District No.
Primary Registration District No.

File No. **22006**
Registered No.
St. Ward)

2. FULL NAME

James Alice Benning
(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 Female
4. COLOR OR RACE White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Married
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Charles P. Benning
6. DATE OF BIRTH (MONTH, DAY AND YEAR) Nov. 27 - 1865
7. AGE YEARS MONTHS DAYS IF LESS than 1 day, ... hrs. or min.
67 6 7

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Retired
(b) General nature of industry, business, or establishment in which employed (or employer) House wife
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) Adair County
(STATE OR COUNTRY) Mo.

10. NAME OF FATHER James A. Smith

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Not known
(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER Carous Elye

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

14. INFORMANT A. B. Benning
(Address) Greentop Mo.

15. FILED June 2, 1933 Mrs. O. P. Young
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) June 4 - 1933

17. I HEREBY CERTIFY, That I attended deceased from June 2 to June 4, 1933
that I last saw her alive on June 4, 1933 and that death occurred, on the date stated above, at 4 m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Brain morbid
catarrh

CONTRIBUTORY (SECONDARY) From (duration) yrs. mos. ds.

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

DID AN OPERATION PRECEDE DEATH? Y DATE OF X

WAS THERE AN AUTOPSY? Y

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed) O. P. Young, Jr. M. D.

Address L. C. Young

*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

Greentop Cemetery 6-5-1933

20. UNDERTAKER ADDRESS

L. C. Young Greentop

MISSOURI STATE BOARD OF HEALTH

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County.....
 Townshp.....
 City..... (No., SL., Ward)

Registration District No.

Primary Registration District No.

File No.

Registered No.

2. FULL NAME

(a) Residence, No., SL., 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.

PERSONAL AND STATISTICAL PARTICULARS

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

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

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

7. AGE..... YEARS..... MONTHS..... DAYS..... IF LESS than 1 day, hrs. 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....., 19..... REGISTRAR.....

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR)..... 19.....

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

THE CAUSE OF DEATH* WAS AS FOLLOWS:

CONTRIBUTORY (SECONDARY).....

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)....., 19..... (Address)..... M. D.

*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.

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