

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.

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

Do not use this space.

NOV 18 1937

1. PLACE OF DEATH

County: *Meramec*  
Township: *Jefferson*  
City: (No. )

Registration District No. *495*  
Primary Registration District No. *5080*

File No. *37987*  
Registered No. *152*

2. FULL NAME

*William DeCatur Bennett*

(a) Residence, No. *Catawissa P.P.#1* St. Ward.

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) *Widower*

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF *Dora Louise Bennett*

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) *July 15 - 1864*

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min. *73 3 14*

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

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

10. Date deceased last worked at this occupation (month and year) *10/27* 11. Total time (years) spent in this occupation *1/4 yrs*

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *St. Louis Mo*

13. NAME *William DeCatur Bennett*

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Virginia*

15. MAIDEN NAME *Annanda Buchanan*

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *St. Louis Mo*

17. INFORMANT *W. B. Bennett* (ADDRESS) *Catawissa Mo*

18. BURIAL, CREMATION, OR REMOVAL PLACE *St. Pauls Church yard* DATE *11/1/37*

19. UNDERTAKER (ADDRESS) *W. B. Bennett*

20. FILED *1705 37 Jantzen & Lawrence* Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *10/28/37* 19

I HEREBY CERTIFY, That I attended deceased *Dr. Oct. 31* 19*37*

I last saw *h* alive on *10/27* Death is said

to have occurred on the date stated above, at *2:20* A.M.

The principal cause of death and related causes of importance were as follows:

*Chronic Myocarditis*

Other contributory causes of importance:

Name of operation Date of What test confirmed diagnosis? Was there an autopsy? *no*

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? *no* If so, specify *Frank Frazier Corcoran* (Signed) *Fester, Mo* (Address)

