

REC'D APR 13 1939

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

11071

Do not use this space.

1. PLACE OF DEATH

(a) County Jackson Registration District No. 398
 (b) Township Bliss Primary Registration District No. 5554 Registered No. 117
 (c) City Independence, Mo. (d) Street No. Beverly Hills Addition St.
 (If death occurred in Hospital or Institution, write its name instead of street and number)
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

Franklin O. Benz
 (a) Residence, No. Beverly Hills Add. Indep. Mo. St. (If nonresident, give city or town and State)
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

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

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF Mrs. Mayme Benz (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Feb. 3, 1875

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
64 1 25

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Retired
 9. Industry or business in which work was done, as saw mill, bank, etc. Mechanic
 10. Date deceased last worked at this occupation (month and year) 11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Kansas City, Mo.FATHER 13. NAME Phillip Benz14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) FranceMOTHER 15. MAIDEN NAME Apollonia Loesch16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Germany17. INFORMANT (ADDRESS) Mrs. Eda B. Witte
Independence, Mo.18. BURIAL, CREMATION, OR REMOVAL PLACE Mt. Washington DATE Mar. 31, 193919. FUNERAL DIRECTOR (NAME) (ADDRESS) John W. Wagner
K. C. Mo.20. FILED 4-3-39 F. L. Cook Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Mar. 28, 1939

22. I HEREBY CERTIFY, That I attended deceased from

Mar. 22, 1939, to Mar. 28, 1939I last saw him alive on Mar. 28, 1939 at 10:30 pm Death is said to have occurred on the date stated above, at 10:30 pm.

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

Cerebral HemorrhageDate of onset
3/22/39

Other contributory causes of importance:

Nephritis

Name of operation Date of

What test confirmed diagnosis? Clinical 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

(Signed) A. E. Dietrichson M. D.(Address) 402 Bryan Bldg., J.P., 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.

8/10/81

STATE OF VIRGINIA
DEPARTMENT OF HEALTH
BUREAU OF VITAL RECORDS

VI 2851

402 Bryant Bldg.,

Dr. D. C. DiDERICHTSON

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,

....., or by

Registered Apprentice No., working under my personal supervision.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.

FILL IN ANSWERS TO ALL SPACES
CHECKED IN RED PENCIL.

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

11071
Do not use this space.

1. PLACE OF DEATH

(a) County Jackson Registration District No. 398
(b) Township Blue Primary Registration District No. 3334 Registered No. 117
(c) City..... (d) Street No..... St.
(If death occurred in Hospital or Institution, write its name instead of street and number)
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

Franklin O. Benz
(a) Residence, No..... St. (If nonresident, give city or town and State)
(Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

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

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 3 - 28 - 1939

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

22. I HEREBY CERTIFY, That I attended deceased from 19..... to....., 19.....

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

I last saw h..... alive on....., 19..... Death is said

7. AGE YEARS MONTHS DAYS If LESS than 1 day,hrs. ormin.
64 1 25

to have occurred on the date stated above, at.....m.

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.....
9. Industry or business in which work was done, as saw mill, bank, etc.....
10. Date deceased last worked at this occupation (month and year).....
11. Total time (years) spent in this occupation.....

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

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

Cerebral Hemorrhage Date of onset

13. NAME

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

Other contributors causes of importance:

15. MAIDEN NAME

nephritis Chronic

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

Name of operation..... Date of.....

17. INFORMANT (ADDRESS)

What test confirmed diagnosis?..... Was there an autopsy?.....

18. BURIAL, CREMATION, OR REMOVAL PLACE..... DATE....., 19.....

23. If death was due to external causes (violence), fill in also the following:

19. FUNERAL DIRECTOR (ADDRESS)

Accident, suicide, or homicide?..... Date of injury....., 19.....

20. FILED....., 19..... Local Registrar.

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) D. C. Diederichsen M. D. e

(Address) 402 Bryant Bldg Ke mo

MAY - 7 1951

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