

REC'D MAY 10 1939

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

13958

Do not use this space.

## 1. PLACE OF DEATH

(a) County Jackson Registration District No. 399  
(b) Township Howe Primary Registration District No. 1002 Registered No. 1712  
(c) City Howe Mo (d) Street No. 170 Gen Hosp 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

(a) Residence, No. 525 Jason Benson St.   
2032 Broadway (Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

## PERSONAL AND STATISTICAL PARTICULARS

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

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) March 17 1900

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.  
19 1 6

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. Cook

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

FATHER

13. NAME Edward T. Benson

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

MOTHER

15. MAIDEN NAME Ida Good

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

17. INFORMANT (ADDRESS) Record Clerk

18. BURIAL, CREMATION, OR REMOVAL

PLACE Charite Rg DATE 4/24 39

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Funerary Home20. FILED Apr 24 1939

Local Registrar.

## MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 4-23-39

22. I HEREBY CERTIFY, That I attended deceased from 4-13-39, 1939, to 4-23-39, 1939.

I last saw him alive on 4-23-39, 1939. Death is said to have occurred on the date stated above, at 8:50 a.m.

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

Post operative ap- pendectomy; Vol- vulus

Date of onset

Other contributory causes of importance:

Name of operation \_\_\_\_\_ Date of \_\_\_\_\_

What test confirmed diagnosis? \_\_\_\_\_ Was there an autopsy? Yes

23. If death was due to external causes (violence), fill in also the following: Accident, suicide, or homicide? \_\_\_\_\_ Date of injury \_\_\_\_\_, 1939

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) P. De Manio, M. D.(Address) 504 Gen Hosp

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.

30-M-1-12-35

1 X14023

STATEMENT TO BE FILED WITH THE DEPARTMENT OF HEALTH

AND TO BE KEPT ON FILE IN THE OFFICE OF THE STATE EMBALMER

IN THE CITY OF CHICAGO

**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.**