

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

14999

Do not use this space.

MAY 18 1939

1. PLACE OF DEATH

(a) County Lewis Registration District No. 380
 (b) Township _____ Primary Registration District No. 4224 Registered No. 9
 (c) City New Franklin (d) Street No. _____
 (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

530 Mrs. Orlan Jackson Bennett
 (a) Residence, No. New Franklin 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 Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Widowed
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND-OF (OR) WIFE OF Thomas Otter Bennett
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Nov. 16 - 1862
 7. AGE YEARS 76 MONTHS 4 DAYS 15 If LESS than 1 day, _____ hrs. or _____ min.
 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Housewife
 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) March 1939
 11. Total time (years) spent in this occupation Life

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Clark Co. Mo.
 13. NAME Madison B. Bash
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Mo.
 15. MAIDEN NAME Isabelle Scott
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Kentucky

17. INFORMANT (ADDRESS) Mrs. B. J. Clegg
New Franklin Mo.

18. BURIAL, CREMATION, OR REMOVAL PLACE McClain DATE 4/3/39

19. FUNERAL DIRECTOR (NAME) (ADDRESS) C. S. Muncey
New Franklin Mo.

20. FILED 4-3- 19 39 Clara V. Landrum
 Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Apr 1 1939
 22. I HEREBY CERTIFY, That I attended deceased from Mar 27 1939, to Apr 1 1939
 I last saw him alive on Apr 1 1939 Death is said to have occurred on the date stated above, at 3:45 p.m.
 The principal cause of death and related causes of importance were as follows:

myocarditis unknown
hypertension unknown
brachitis
arteriosclerosis

Other contributory causes of importance:
Hypertension unknown
brachitis
arteriosclerosis

Name of operation _____ Date of _____
 What test confirmed diagnosis? none 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) C. S. Muncey M. D.
 (Address) New Franklin Mo.

RECEIVED
District Health Officer No. 8
District File Number
Date Filed 3/10/39

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. 3515

P. O. Address New Franklin Mo

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.