

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

33127  
Do not use this space.

1. PLACE OF DEATH **DECEASED** **DEATH** **9 1939**  
 (a) County Nodaway Registration District No. 617  
 (b) Township White Cloud Primary Registration District No. 5818 Registered No. 13  
 (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 WILLIE H BENHAM  
 (a) Residence, No. Barnard Mo St.  (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) Married  
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (or WIFE OF) Amanda  
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 10-10-69  
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, ..... hrs. or ..... min.  
69 11 15  
 OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Farmer  
 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) 2-1-1939 11. Total time (years) spent in this occupation Lifetime  
 12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Indigo Ia  
Iowa  
 FATHER 13. NAME John W Benham  
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Iowa  
 MOTHER 15. MAIDEN NAME Eliya Ann Lamore  
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Illinois  
 17. INFORMANT (ADDRESS) Regrett Benham  
Maryville  
 18. BURIAL, CREMATION, OR REMOVAL PLACE Chris Cemetery DATE 9/30 1939  
 19. FUNERAL DIRECTOR (NAME) (ADDRESS) Chris Dumbud  
Local Registrar  
 20. FILED Sept 30 1939

**MEDICAL CERTIFICATE OF DEATH**

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Sep-27 - 1939  
 22. I HEREBY CERTIFY, that I attended deceased from sep-18 1939, to death 1939.  
 I last saw h. Li alive on sep 27 1939. Death is said to have occurred on the date stated above, at 4 A m.  
 The principal cause of death and related causes of importance were as follows:  
Cerebral Hemorrhage  
 Date of onset .....  
 Other contributory causes of importance: HTN  
 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 .....  
 (Signed) W. Lee M. D.  
 (Address) Polk Co 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.

1039-7363  
OCT 17 1939

**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.....

*William Campbell*, Registered Apprentice No. ....  
working under my personal supervision.

Signed

*William Campbell*

Licensed Embalmer No. *2650*

P. O. Address *Wayville*

**Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to conform 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

33127  
Do not use this space.

1. PLACE OF DEATH  
 (a) County Madison Registration District No. 617  
 (b) Township White Cloud Primary Registration District No. 3818  
 (c) City..... (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 Wallie H. Benham  
 (a) Residence, No. .... St.   
 (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 m  
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF .....

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 10-10-1869

7. AGE YEARS MONTHS DAYS If LESS than 1 day, ..... hrs. or ..... min.  
69 11 17

OCCUPATION  
 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.....

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

FATHER  
 13. NAME Indiana  
 14. BIRTHPLACE (CITY OR TOWN)..... (STATE OR COUNTRY)..... Iowa

MOTHER  
 15. MAIDEN NAME .....

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

17. INFORMANT (ADDRESS).....

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

19. FUNERAL DIRECTOR (ADDRESS).....

20. FILED 9/30 1939 Chas. Humboldt Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 9-27 1939

22. I HEREBY CERTIFY, That I attended deceased from ..... to....., 19.....  
 I last saw h..... alive on....., 19..... Death is said to have occurred on the date stated above, at..... m.  
 The principal cause of death and related causes of importance were as follows:  
 Date of onset

Other contributory causes of importance:

Name of operation..... Date of.....  
 What test confirmed diagnosis?..... Was there an autopsy?.....

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?.....  
 If so, specify W Logan Wood M. D.  
 (Signed) Bob Brown (Address) ma

SUPPLEMENTARY

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.  
 CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

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