

JAN 8 1940

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

42917
Do not use this space.

1. PLACE OF DEATH
 (a) County Caldwell Registration District No. 98
 (b) Township Kingston Primary Registration District No. 5144
 (c) City _____ (d) Street No. _____ Registered No. 13
 (e) Length of residence in city or town where death occurred 5 yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.
 (If death occurred in Hospital or Institution, write its name instead of street and number)

2. PRINT FULL NAME Marion Washington Bennett
 (a) Residence, No. _____ 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) Divorced

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 4th. 8 1863

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
76 10 8

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Labor

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) Davies Co. Mo

13. NAME Washington Bennett

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Green Co. Ky.

15. MAIDEN NAME Abbie Early

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Dake Co. Ky.

17. INFORMANT (ADDRESS) Harvey Bennett Kingston Mo

18. BURIAL, CREMATION, OR REMOVAL PLACE Trooper Cemetery DATE Dec 18 1939

19. FUNERAL DIRECTOR (NAME) (ADDRESS) T. M. Dacey & Son Greenknudge Mo

20. FILED Dec 18th 1939 Med. Beth Hill Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Dec 16th 1939

22. I HEREBY CERTIFY, That I attended deceased from Dec 15 1939 to Dec 16 1939
 I last saw him alive on Dec 15 1939 Death is said to have occurred on the date stated above, at 7:30 A. m.
 The principal cause of death and related causes of importance were as follows:

<u>Chronic Myocarditis</u>	<u>2</u>
<u>Astoria Sclerosis</u>	<u>2</u>

Other contributory causes of importance: 9 & C

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) T. M. Dacey M. D.
 (Address) Harwood, 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.

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.....

T. McBeek

....., Registered Apprentice No.....

working under my personal supervision.

Signed *T. McBeek*

Licensed Embalmer No. *1570*

P. O. Address *Breakenridge W*

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.