

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.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

3027

State File No.

Registrar's No.

FILED FEB 16 1940

Registration District No. 546 Primary Registration District No. 575

1. PLACE OF DEATH:

(a) County Maries County
(b) City or town St. James, Mo. Route #1
(c) Name of hospital or institution NONE
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution ✓
In this community LIFETIME years, months or days 52 YEARS (Specify whether years, months or days)

8. (a) PRINT FULL NAME John BENDER 536

8. (b) If veteran, name war NONE 8. (c) Social Security No. NONE

4. Sex MALE 5. Color or race WHITE 6. (a) Single, widowed, married, divorced ✓
6. (b) Name of husband or wife ✓ 6. (c) Age of husband or wife if alive 27 years (Month) (Day) (Year)
7. Birth date of deceased April 27 1851 (Month) (Day) (Year)

8. AGE: Years 88 Months 9 Days ✓ If less than one day hr. min.

9. Birthplace SWITZERLAND (City, town, or county) (State or foreign country)

10. Usual occupation FARMER

11. Industry or business ✓

MOTHER FATHER { 12. Name Not known 9
13. Birthplace Not known 9
14. Maiden name Not known 9
15. Birthplace Not known 9
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature M. A. BENDER
(b) Address St. Louis, Mo.

17. (a) (b) Date thereof (Month) (Day) (Year)
(Burial, cremation, or removal) SEWELL CEMETERY
(c) Place: burial or cremation

18. (a) Signature of funeral director John A. Koopman
(b) Address St. Louis, Mo. 1181

19. (a) (b) (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Phelps
(c) City or town ST JAMES
(If outside city or town limits, write "RURAL")
(d) Street No. ✓ (If rural, give location)
(e) If foreign born, how long in U. S. A. 52 years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month January day 26 th
year 1940 hour 3 minute 55 P. M.

21. I hereby certify that I attended the deceased from January 21, 1940, to January 26, 1940;
that I last saw him alive on January 26, 1940;
and that death occurred on the date and hour stated above.

Immediate cause of death Bronchial pneumonia including cystic bronchitis Duration

Due to

Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations

Of autopsy

PHYSICIAN

Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify)
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work? (Specify type of place) (e) Means of injury

23. Signature C. V. Hammler (M. D. 1938)
Address St. James Date signed 1.26.40

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.

RECEIVED

District Health Officer No. 5,

Signed.....

District File Number 240200

Licensed Embalmer No.....

Date Filed 21440

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

3027

Do not use this space.

1. PLACE OF DEATH

(a) County Marion Registration District No. 546
(b) Township Johnson Primary Registration District No. 5735
(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.

Registered No. 2

2. PRINT FULL NAME

(a) Residence, No. John Bender 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 (write the word) Wid
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) _____
7. AGE YEARS 88 MONTHS 9 DAYS 1 If LESS than 1 day, _____ hrs. or _____ min.
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 _____
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) _____
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 Mar 13, 1940, Sam A. Warner Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 1-26, 1940

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

I last saw him _____ 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:

Other contributory causes of importance: _____
Date of onset _____

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 _____
(Signed) C. J. Hammel, M. D.
(Address) St. James Mo

S-3027