

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH
1003

State File No. 30664
7941
Registrar's No. _____

Registration District No. 791

Primary Registration District No. _____

1. PLACE OF DEATH:

(a) County _____
(b) City or town St. Louis, Mo
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution BARNES HOSPITAL
(If not in hospital or institution, write street number or location) 1
(d) Length of stay: In hospital or institution _____ (Specify whether _____)
In this community 3 days
years, months or days

3. (a) PRINT FULL NAME THOMAS CHARLES BENNETT

3. (b) If veteran, name war None 3. (c) Social Security No. None

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Rosie 6. (c) Age of husband or wife if alive 66 years

7. Birth date of deceased Nov 18 1871
(Month) (Day) (Year)

8. AGE: Years 68 Months 10 Days 2 If less than one day _____ hr. _____ min.

9. Birthplace Van Buren Ark
(City, town, or county) (State or foreign country)

10. Usual occupation Farmer

11. Industry or business _____

12. Name Wm Bennett

13. Birthplace Illinois
(City, town, or county) (State or foreign country)

14. Maiden name Melvina Cochran

15. Birthplace Illinois
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature [Signature]

(b) Address East St. Louis, Ill.

17. (a) Burial (b) Date of death Sept 21 1940
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Franklin Co. Illinois

18. (a) Signature of funeral director [Signature]

(b) Address East St. Louis, Illinois

19. (a) SEP 21 1940 (b) J. F. [Signature]
(Date received local registrar) (Signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Illinois (b) County Franklin
(c) City or town Whittington NR
(If outside city or town limits, write "RURAL")
(d) Street No. R.R. #1 (If rural, give location)
(e) If foreign born, how long in U. S. A? ✓ years

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 9 day 20
year 1940 hour 11 minute 25 M.

21. I hereby certify that I attended the deceased from 9-17, 1940 to 9-20, 1940

that I last saw him alive on 9-20-40, 1940; and that death occurred on the date and hour stated above.

Immediate cause of death CARCINOMA OF BLADDER 4 + Mos
URINARY Duration

Due to _____
Due to 51

Other conditions PARAPLEGIA DUE TO 3 DAYS
(Include pregnancy within 3 months of death) METASTASIS

Major findings: Of operations _____

Of autopsy _____

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 Karl [Signature] (M. D. or other) MD.

Address BARNES HOSPITAL Date signed 9/20/40

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.

I X1951

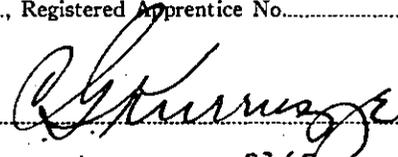
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STATEMENT BY LICENSED EMBALMER

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. 3162

P. O. Address East St. Louis, Ill.

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.