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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED OCT 10 1940

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 31456

Registration District No. 85 — Primary Registration District No. 1001 — Registrar's No. 1017

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

11 (a) County BUCHANAN

5 (b) City or town ST. JOSEPH
(If outside city or town limits, write "RURAL" and name of township)

7 (c) Name of hospital or institution: STATE HOSPITAL No. 2
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution two years, 3 (Specify whether
In this community 11 months, 25 days
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Buchanan

(c) City or town St. Joseph
(If outside city or town limits, write "RURAL")

0 (d) Street No. Buchanan County Home
(If rural, give location)

(e) If foreign born, how long in U. S. A.? — years.

3. (a) PRINT FULL NAME EMERETTA BENGER

3. (b) If veteran, name war —

3. (c) Social Security No.

4. Sex f

5. Color or race Wh

6. (a) Single, widowed, married, divorced single

6. (b) Name of husband or wife —

6. (c) Age of husband or wife if alive — years

7. Birth date of deceased ? (Month) ? (Day) (Unknown) (Year)

8. AGE: Years 81 (about) Months ? Days ? If less than one day hr. min.

9. Birthplace Iowa (City, town, or county) (State or foreign country) 1

10. Usual occupation Housework 4

11. Industry or business 9

FATHER
12. Name ?
13. Birthplace ? (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name ?
15. Birthplace ? (City, town, or county) (State or foreign country)

16. (a) Informant Hospital Records
(b) Address State Hosp. #2 St. Joseph, Mo.

17. (a) removal (Burial, cremation, or removal) (b) Date thereof 9-18-40 (Month) (Day) (Year)
(c) Place: burial or cremation Kirksville, Mo.

18. (a) Signature of funeral director Summers and Flinchpaugh
(b) Address Kirksville, Mo.

19. (a) 9/18/40 (Date received local registrar) (b) H J Nietlebush (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept. day 16th year 1940 hour 2 minute 45 a. M.

21. I hereby certify that I attended the deceased from July 1st, 1940, to Sept. 14th, 1940, that I last saw her alive on September 14, 1940 and that death occurred on the date and hour stated above.

Immediate cause of death Bronchopneumonia

Due to

Due to

Other conditions Fracture Left Femur 26 days
(Include pregnancy within 3 months of death)
Senile dementia

Major findings:
Of operations —
Of autopsy —

Duration

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) accident
(b) Date of occurrence August 20. 1940
(c) Where did injury occur? St. Hospital (City or town) 14 (County) St. Joseph (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? Public Place (Hospital) (Specify type of place)
85 While at work? (e) Means of injury Fracture

23. Signature J K Thompson (M. D.) Tate
Address State Hospital #2 Date signed 9-18-40

(Licensed Embalmer's Statement on Reverse Side)

ST. JOSEPH

NOV 19 1943

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.....

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wi the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.