

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. **36616**

Registration District No. **878**

Primary Registration District No. **4531**

Registrar's No. **14**

**1. PLACE OF DEATH:**  
 (a) County Vernon  
 (b) City or town Sheldon  
 (If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution:  
Homacher  
 (If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution 1 mo.  
 (Specify whether  
 In this community \_\_\_\_\_  
 years, months or days)

**3. (a) PRINT FULL NAME** BENJAMIN HAMPTON FERRILL  
**3. (b) If veteran,** name war \_\_\_\_\_ **3. (c) Social Security** No. \_\_\_\_\_

**4. Sex** Male **5. Color or** race  
**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** July 20 - 1875  
 (Month) (Day) (Year)

**8. AGE:** Years 65 Months 2 Days 10  
 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

**9. Birthplace** Barton Co Rural Missouri  
 (City, town, or county) (State or foreign country)

**10. Usual occupation** Farming

**11. Industry or business** \_\_\_\_\_

**MOTHER FATHER**  
**12. Name** Benjamin H Ferrill  
**13. Birthplace** St Charles Mo  
 (City, town, or county) (State or foreign country)  
**14. Maiden name** Lois Huffman  
**15. Birthplace** St Charles Mo  
 (City, town, or county) (State or foreign country)

**16. (a) Informant** Mrs Alf Landigham  
 (b) Address Sheldon Mo  
**17. (a) (b) Date thereof** Oct. 2 - 1946  
 (Burial, cremation, or removal) (Month) (Day) (Year)  
 (c) Place: burial or cremation Howell cemetery

**18. (a) Signature of funeral director** G B Bannister  
 (b) Address Sheldon Mo  
**19. (a) (b) (c) (d)** Oct 1 - 1946 Carroll T. Bannister  
 (Date received local registrar) (Registrar's signature)

**2. USUAL RESIDENCE OF DECEASED:**  
 (a) State Missouri (b) County Barton  
 (c) City or town Millford Mo  
 (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? \_\_\_\_\_ years.

**MEDICAL CERTIFICATION**  
**20. DATE OF DEATH:** Month Sept day 30  
 year 1946 hour 8 minute 45 AM

**21. I hereby certify that I attended the deceased from** June 18, 1946 to Sept 30, 1946  
 that I last saw him alive on Sept 30, 1946  
 and that death occurred on the date and hour stated above.

Immediate cause of death: Hypostatic pneumonia Duration 2 days  
 Due to: Chronic myocarditis 68 yrs.  
Light hypothyroidism 3 yrs.  
 Due to: Asites 2 mo.

Other conditions \_\_\_\_\_  
 (Include pregnancy within 3 months of death)

**PHYSICIAN**  
 Major findings: \_\_\_\_\_  
 Of operations: \_\_\_\_\_  
 Of autopsy: \_\_\_\_\_  
 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?  
 \_\_\_\_\_ (Specify type of place) (e) Means of injury \_\_\_\_\_  
**23. Signature** Thomas G. Bennett (M. D. or other) JMD  
 Address Sheldon Mo. Date signed 10-1-46

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

11-10-39  
5-17-39  
X21492

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RECEIVED

District Health Officer No. 7,

District File Number 11-40-1566

Date Filed 11-6-40

**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 Person

Registered Apprentice No. \_\_\_\_\_

working under my personal supervision.

Signed Carroll T. Beery

Licensed Embalmer No. 2385

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.

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 36616

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

Registration District No. 878

Primary Registration District No. 4531

Registrar's No. \_\_\_\_\_

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

1. PLACE OF DEATH:

(a) County Weymouth  
(b) City or town Sheldon  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
\_\_\_\_\_  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_  
(Specify whether \_\_\_\_\_)  
In this community \_\_\_\_\_  
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State \_\_\_\_\_ (b) County \_\_\_\_\_  
(c) City or town \_\_\_\_\_  
(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.? \_\_\_\_\_ years.

3. (a) PRINT FULL NAME Benjamin Hampton Ferrell

MEDICAL CERTIFICATION

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

20. DATE OF DEATH: Month 9 day 30  
year 1940 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

4. Sex m 5. Color or race w 6. (a) Single, widowed, married, divorced 2

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband, or wife, if alive \_\_\_\_\_ years.

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

8. AGE: Years Months Days If less than one day  
65 2 10 hr. \_\_\_\_\_ min.

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

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

12. Name \_\_\_\_\_

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

14. Maiden name \_\_\_\_\_

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

16. (a) Informant \_\_\_\_\_

(b) Address \_\_\_\_\_

17. (a) \_\_\_\_\_ (b) Date thereof (Month) (Day) (Year)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

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

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_; that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_; and that death occurred on the date and hour stated above.

Immediate cause of death  
Hypostatic Pneumonia  
Bronchopneumonia  
Due to Chr. inf. Carditis  
Duration Right Hydrothorax  
abscess

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations 97c

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) (b) Means of injury

23. Signature Thomas J. Duckett (M. D. or other) MD  
Address Sheldon Mo Date signed 12/20/40

Duration  
PHYSICIAN  
Underline the cause to which death should be charged statistically.

