S. No. ...
...-17-39
I X21492

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 37390

Registration District No. 791 Primary Registration District No. 1003 Registrar's No. 9663

FILED DEC 11 1948

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

1. PLACE OF DEATH:

(a) County

(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: En Route to City Hospital #1
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution (Specify whether years, months or days)

In this community 5

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County

(c) City or town St. Louis 25
(If outside city or town limits, write "RURAL")

(d) Street No. 110 ½ N. 6th St
(If rural, give location)

(e) If foreign born, how long in U. S. A.? years. 0

3. (a) PRINT FULL NAME Benjaman Franklin Dechane

3. (b) If veteran, name war Unknown

3. (c) Social Security No. Unknown

4. Sex Female

5. Color or race White

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 Unknown (Month) (Day) (Year)

8. AGE: Years About 68 | Months | Days | If less than one day hr. min.

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

10. Usual occupation Bill Poster

11. Industry or business Unemployed 7

FATHER
12. Name Unknown 9
13. Birthplace Unknown (City, town, or county) 1 (State or foreign country)

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

16. (a) Informant James J. Fitzsimmons

(b) Address Coroners Office

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 27 1940 (Month) (Day) (Year)

(c) Place: burial or cremation Minneapolis Minn

18. (a) Signature of funeral director Peetz Brothers

(b) Address 3029 Lafayette Ave

19. (a) NOV 25 1940 (Date received local registrar) (b) J. F. Bredeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 24th day November year 1940 hour 12:00 minute Pm M.

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

Immediate cause of death Aortic Stenosis with fatty degeneration of myocardium; Contrib: Chronic Parenchymatous Nephritis

Due to

Due to

Other conditions
(Include pregnancy within 3 months of death)

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)

(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)

While at work? (e) Means of injury

23. Signature James J. Fitzsimmons (Coroner or ~~M. D.~~ or other)

Address Date signed

(Licensed Embalmer's Statement on Reverse Side)

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 Frank D. Owens

Licensed Embalmer No. 2245

P. O. Address St Louis Mo

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.

S. No. 2B
0—4-25-41
I X27852

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 37390

Registration District No. 791 Primary Registration District No. 1003 Registrar's No. 9663

SUPPLEMENTARY

1. PLACE OF DEATH:

(a) County St Louis

(b) City or town (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) Citizen of foreign country? (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME Benjamin Franklin Dechane

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex Male F

5. Color or race W

6. (a) Single, widowed, married, divorced 8

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 aft 88 Months Days If less than one day hr. min.

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

10. Usual occupation

11. Industry or business

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

(b) Address

17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)

(c) Place: burial or cremation

18. (a) Signature of funeral director

(b) Address

19. (a) 7-14-41 (Date received local registrar) (b) J F Bredick (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov day 24 year 1940 hour minute M.

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

	Duration
Immediate cause of death	
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? (Specify type of place)

While at work? (e) Means of injury Car

23. Signature James J Fitzsimmons (M. D. or other)

Address Date signed