

MAR 14 1944

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

6799
Do not use this space.

1. PLACE OF DEATH

(a) County Dallas Registration District No. 244
(b) Township Larper Primary Registration District No. 033830
(c) City Windyville or (d) Street No. 1 Registered No. _____
(If death occurred in Hospital or Institution, write its name instead of street and number) St. _____
(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.

2. PRINT FULL NAME Benjamin Franklin Hildebrand

(a) Residence, No. Windyville mo St. (If nonresident, give city or town and State)
(Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) M

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Eva Hildebrand

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 2-20-1854

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. min.
86 11 28

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Farmer
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) Unknown

13. NAME
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

15. MAIDEN NAME
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

17. INFORMANT H. H. Scott
(ADDRESS) Buffalo Mo.

18. BURIAL, CREMATION, OR REMOVAL PLACE Pea Ridge DATE 2-19 1941

19. FUNERAL DIRECTOR (NAME) L. B. Jones
(ADDRESS) Buffalo Mo.

20. FILED 3/10 1941 Mrs C B Reed
Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 2-18 1941

22. I HEREBY CERTIFY, That I attended deceased from on 1-17- 1941, to _____, 19____

I last saw him alive on 1-17- 1941. Death is said to have occurred on the date stated above, at 4 a.m.

The principal cause of death and related causes of importance were as follows:

Chronic Cardio renal disease with hyper tension & arterio sclerosis & influenza

Date of onset 1 week

Other contributory causes of importance: 12/10

Name of operation _____ Date of _____
What test confirmed diagnosis? renal 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? NO
If so, specify _____

(Signed) J. Blumner D. M. D.
(Address) Buffalo Mo.

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

K. 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.

FORM 9-10-38 I X18605

RECEIVED

District Health Officer No. 7,

District File Number 3-41-548

Date Filed 3-13-41

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 with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.