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Vernice Phillips Greensburg

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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No.

FILED MAY 12 1943

Registration District No. 326

Primary Registration District No. 6108

Registrar's No. 12

1. PLACE OF DEATH

(a) County Scotland

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

(c) Name of hospital or institution: 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..... (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County Scotland

(c) City or town Greensburg
(If outside city or town limits, write "RURAL")

(d) Street No..... (If rural, give location)

(e) Citizen of foreign country? NO (Yes or No)
If yes, name country.....

3. (a) PRINT FULL NAME Robert E. Bennett

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 2nd
year 1943 hour 4A.M. minute..... M.

21. I hereby certify that I attended the deceased from March 15th. 1943, to April 2nd 1943, that I last saw him alive on April 6th. 1943 and that death occurred on the date and hour stated above.

4. Sex male 5. Color or race White

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

6. (b) Name of husband or wife..... Missie Bennett 6. (c) Age of husband or wife if alive..... 61 years

7. Birth date of deceased..... June 5 1882
(Month) (Day) (Year)

Immediate cause of death.....
Organic Disease of Heart with
resulting cardio-renal stases
Due Arteriosclerosis

Due to.....

Other conditions.....
(Include pregnancy within 3 months of death)

131a

8. AGE: Years Months Days If less than one day

60 10 28 hr. min.

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

10. Usual occupation Farmer.

11. Industry or business.....

12. Name John C. Bennett

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

14. Maiden name Louisa E. Rogue

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

Major findings:
Of operations.....

Of autopsy.....

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

16. (a) Informant Mrs Minnie Bennett

(b) Address Greensburg Mo

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

(c) Place: burial or cremation..... Bullion

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.....

18. (a) Signature of funeral director..... Wentworth

(b) Address Memphis Mo

19. (a) 4/6/1943 (b) Bertrice Wilson
(Date received local registrar) (Registrar's signature)

23. Signature W. E. Alexander (M. D. com)
Address Memphis Date signed 4/6/43

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

MOTHER FATHER

RECEIVED

District Health Officer No. 10

District File Number 5-43-839

Date Filed MAY 10 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.....

Frank Gerth

Licensed Embalmer No. 4256

P. O. Address Memphis

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, fact should be so stated above.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No.

Registration District No. 326

Primary Registration District No. 6108

Registrar's No. 12

1. PLACE OF DEATH:

(a) County Scotland
(b) City or town Rural / John Jays
(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)

3. (a) PRINT FULL NAME Robert E. Bennett

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

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

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

7. Birth date of deceased June 25 1900
(Month) (Day) (Year)

8. AGE: Years 60 Months 10 Days 25 If less than one day min.

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

10. Usual occupation.....

11. Industry of business.....

MOTHER FATHER { 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) (Burial, cremation, or removal) (b) Date thereat Apr 6 - 43
(Month) (Day) (Year)

(c) Place: burial or cremation.....

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

(b) Address.....

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

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.....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 19 year 1943 hour..... minute..... M.

21. I hereby certify that I attended the deceased from..... 19.....; that I last saw him/her alive on..... 19.....; and that death occurred on the date and hour stated above. Immediate cause of death.....

Due to.....

Due to.....

Other conditions..... (Include pregnancy within 3 months of death)

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..... (M. D. or other).....

Address..... Date signed.....

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

SUPPLEMENTARY

S-15630