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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. 3345

FILED FEB 9 1944

Registration District No. 1 Primary Registration District No. 3034 Registrar's No. 3

1. PLACE OF DEATH:
(a) County Lafayette
(b) City or town Higginsville, Mo.
(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 years, months or days)
In this community

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Lafayette 54
(c) City or town Higginsville 2
(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 Benricke R. Canada
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 Married
6. (b) Name of husband or wife Ella Canada
6. (c) Age of husband or wife if alive about 72 years
7. Birth date of deceased April 29, 1861 (Month) (Day) (Year)

8. AGE: Years 82 Months 8 Days 17 If less than one day hr. min.

9. Birthplace Boone County, Missouri (City, town, or county) (State or foreign country) O
10. Usual occupation Retired Supt. & Nurse
11. Industry or business
FATHER
12. Name Hansen Canada
13. Birthplace Do ~~Not Know~~ Sadland (City, town, or county) (State or foreign country) 4
MOTHER
14. Maiden name Do Not Know
15. Birthplace Do Not Know (City, town, or county) (State or foreign country) 9
16. (a) Informant Mrs R Canada
(b) Address Higginsville, Mo.
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/4/44 (Month) (Day) (Year)
(c) Place: burial or cremation City Cemetery
18. (a) Signature of funeral director Albert Wolfe Sons
(b) Address Higginsville, Mo.
19. (a) 1-7-1944 (Date received local registrar) (b) Dr. W.A. Brackleir (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 3
year 1944 hour 1 minute 30 A.M.
21. I hereby certify that I attended the deceased from Nov 20 1943, to Jan 3 1944
that I last saw him alive on Jan 2 1944
and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Gangrene rt leg -	3 days
Thrombosis femoral artery rt	5 days.
Chronic Valvular disease - about 5 yrs.	

Due to
Due to
Other conditions (Include pregnancy within 3 months of death) 92d
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

23. Signature W. B. Lemmenmx (M. D. or other) MD
Address Higginsville, Mo. Date signed 1/6/1944

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(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 8,
District File Number .....
Date Filed 2-8-44

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 Forrest A. Hoefer

Licensed Embalmer No. 4358

P. O. Address Higginsville 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, fact should be so stated above.