

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED JAN 12 1945

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **41022**

Registration District No. **94**

Primary Registration District No. **5345**

Registrar's No. **1**

1. PLACE OF DEATH:

(a) County **DADE**
(b) City or town **SAC TOWNSHIP**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: **10 MI. N.E. GREENFIELD**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **NONE** (Specify whether years, months or days)
In this community **8 YEARS**

3. (a) PRINT FULL NAME **THELMA JEWELL BENNETT**

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

4. Sex **F** 5. Color or race **W** 6. (a) Single, widowed, married, divorced **SINGLE**
6. (b) Name of husband or wife **None** 6. (c) Age of husband or wife if alive **years**
7. Birth date of deceased **NOVEMBER 23 1936**
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
8 0 13 hr. min.

9. Birthplace **DADE Co. MISSOURI**
(City, town, or county) (State or foreign country)

10. Usual occupation **SCHOOL GIRL**

11. Industry or business

12. Name **LLOYD BURNETT**
13. Birthplace **MISSOURI**
(City, town, or county) (State or foreign country)
14. Maiden name **CORA DILL**
15. Birthplace **MISSOURI**
(City, town, or county) (State or foreign country)

16. (a) Informant **Lloyd Dill**
(b) Address **Greenfield MO**

17. (a) **BURIAL** (b) Date thereof **12-10-44**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **CORRY CEMETERY**

18. (a) Signature of funeral director **Sam E. Sweeney Jr.**
(b) Address **Greenfield MO**

19. (a) **12-14-44** (b) **Kyle Kirby**
(Date received by registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **MISSOURI** (b) County **DADE** **29**
(c) City or town **RURAL** **1**
(If outside city or town limits, write "RURAL")
(d) Street No. **10 MI. N.E. GREENFIELD** **14**
(If rural, give location)
(e) Citizen of foreign country? **No** (Yes or No)
If yes, name country **No**

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **DECEMBER** day **7**
year **1944** hour **3** minute **30** A. M.
21. I hereby certify that I attended the deceased from **12 PM Dec 6 to 3 AM Dec 7, 1944**
that I last saw her alive on **Dec 6, 10 PM, 1944**
and that death occurred on the date and hour stated above.

Immediate cause of death **Asphyxiated**
Due to **General Peritonitis**

Other conditions **1211**
(Include pregnancy within 3 months of death)

Major findings: Of operations **no operation**
Of autopsy **wound**
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) **None**
(b) Date of occurrence **None**
(c) Where did injury occur? **None**
(d) Did injury occur in or about home, on farm, in industrial place, in public place? **None**

While at work? **None** (Specify type of place) (a) Means of injury **None**
23. Signature **B B Kirby** (M. D. or other)
Address **Dradoville Mo** Date signed **Dec 14 1944**

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

RECEIVED

District Health Officer No. 6;

District File Number 145-9

Date Filed JAN 9 1945

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

Sam E. Senseney Jr.

Licensed Embalmer No. 4099

P. O. Address Shenfield 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.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 41022

Registration District No. 94

Primary Registration District No. 5341

Registrar's No. _____

1. PLACE OF DEATH:

- (a) County Dade
(b) City or town San Jusep
(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)

3. (a) PRINT
FULL NAME

Thelma J. (BENNETT)

3. (b) If veteran,
name war _____

3. (c) Social Security
No. _____

4. Sex F 5. Color or race W 6. (a) Single, widowed, married,
divorced X
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if
alive _____ years
7. Birth date of deceased Nov 23
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
8 0 30 10 min.

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

10. Usual occupation _____

11. Industry or business _____

12. Name Clayd Bennett
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 _____
(Burial, cremation, or removal) (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)

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 Dec day _____
year 1944 hour _____ minute _____ M.
21. I hereby certify that I attended the deceased from _____ 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 _____

Duration _____

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 sta-
tistically.

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 _____

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

41022