

FILED FEB 15 1945

Registration District No. 170

Primary Registration District No. 5633

Registrar's No. ....

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

1. PLACE OF DEATH:

(a) County Laclede  
(b) City or town Phillipsburg Union  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: my  
(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 Missouri (b) County Laclede  
(c) City or town Phillipsburg  
(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 BENJAMIN FRANKLIN Rector

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. none

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

6. (b) Name of husband or wife Allie Rector 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased March 31 1869  
(Month) (Day) (Year)

8. AGE: Years 75 Months 7 Days 20 If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

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

10. Usual occupation Farmer

11. Industry or business \_\_\_\_\_

12. Name Joel C. Rector

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

14. Maiden name Mary Kilburn

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

16. (a) Informant Mrs. Lucy Casper

(b) Address Phillipsburg Mo.

17. (a) Burial (b) Date thereof 1-23-45  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Old Salem Cemetery

18. (a) Signature of funeral director W.E. Hoernan

(b) Address Lebanon Mo.

19. (a) Feb-1-45 (b) Geo. Roper  
(Date received local registrar) (Signature)

MEDICAL CERTIFICATION

23. DATE OF DEATH: Month Jan day 21  
year 1945 hour 6 minute 15 A.M.

21. I hereby certify that I attended the deceased from Oct 30  
1939 to Jan 20, 1945

that I last saw him alive on Jan 20, 1945  
and that death occurred on the date and hour stated above.

Immediate cause of death Chronic Nephritis

Due to \_\_\_\_\_

Due to 31

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) \_\_\_\_\_  
What work? \_\_\_\_\_ (e) Years of injury \_\_\_\_\_

23. Signature Edward J. ... M.D. or other \_\_\_\_\_

Address Phillipsburg Mo Date signed 1/22/45

1090

Received

Laclede County Health Unit

File No.

Date Filed

1009 S-10

2/17/45

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 *Dorsey M. Howe*

Licensed Embalmer No. *4222*

P. O. Address *Lebanon, 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.