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

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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 25342

FILED AUG 4 1945

Registration District No. .... Primary Registration District No. 6272 Registrar's No. ....

1. PLACE OF DEATH:
(a) County Worth
(b) City or town Alendale Rural Allen
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 2½ mile South East of Alendale
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution .... In this community One year 6 months (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Worth 113
(c) City or town Alendale Rural 0
(If outside city or town limits, write "RURAL")
(d) Street No. 2½ Mile S E of Alendale 2200
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country ....

3. (a) PRINT FULL NAME Benjamin Whited
3. (b) If veteran, name war ....
3. (c) Social Security No. ....

4. Sex M 0
5. Color or race W
6. (a) Single, widowed, married, divorced W 7
6. (b) Name of husband or wife Luthena Whited Deceased
6. (c) Age of husband or wife if alive .... years
7. Birth date of deceased Apr (Month) 30 (Day) 1860 (Year)

8. AGE: Years	Months	Days	If less than one day
85	3		hr. min.

9. Birthplace Don't no (City, town, or county) Missouri (State or foreign country)
10. Usual occupation Retired Farmer
11. Industry or business ....
FATHER
12. Name Thomas Whited
13. Birthplace Not Known (City, town, or county) 9 (State or foreign country)
MOTHER
14. Maiden name Not Known
15. Birthplace Not Known (City, town, or county) 9 (State or foreign country)
16. (a) Informant Sherman Whited
(b) Address Martinsville Mo
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 1 1945 (Month) (Day) (Year)
(c) Place: burial or cremation Loan Star
18. (a) Signature of funeral director W G Noble
(b) Address New Hampton Mo.
19. (a) Aug. 4 1945 (Date received local registrar) (b) Maymie Rinehart (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 30 year 1945 hour 9 minute 15 a.M.
21. I hereby certify that I attended the deceased from 3-5-45, 19...., to July 30 1945 that I last saw him alive on July 27 1945 and that death occurred on the date and hour stated above.

Immediate cause of death Carcinoma of Prostate — Duration 1 yr
Due to ....
Due to ....
Other conditions (Include pregnancy within 3 months of death) Mitral Insufficiency of heart — 5 yrs
Major findings:
Of operations ....
Of autopsy no 5/6

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 [illegible] M.D. (M. D. or other)
Address [illegible] Mo. Date signed 7-30-45

1385

(Licensed Embalmer's Statement on Reverse Side)

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 Me

....., Registered Apprentice No.....

working under my personal supervision.

Signed W G Noble

Licensed Embalmer No. 2904

P. O. Address Newhampton 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.