

**FILED** NOV 28 1945

Registration District No. 168

Primary Registration District No. 4257

Registrar's No. 4

1. PLACE OF DEATH:

(a) County Lobson  
(b) City or town Lecton, 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 3 months (Specify whether years, months or days)

3. (a) PRINT FULL NAME Verne Byron Benson

3. (b) If veteran, name war World War I. 3. (c) Social Security No. /

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married  
6. (b) Name of husband or wife Vera Mae Benson 6. (c) Age of husband or wife if alive 45 years  
7. Birth date of deceased July 17 (Month) (Day) (Year)

8. AGE: Years 55 Months Days If less than one day hr. min.

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

10. Usual occupation Farmer Retired

11. Industry or business

12. Name Lidney R. Benson  
13. Birthplace Iowa (City, town, or county) (State or foreign country)  
14. Maiden name Mary Cathine Woods  
15. Birthplace Iowa (City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Vera Benson  
(b) Address Lecton Mo.

17. (a) Burial (b) Date thereof 11-12-1945 (Month) (Day) (Year)  
(c) Place: burial or cremation Shannon Mound

18. (a) Signature of funeral director H. B. Branninger  
(b) Address Lecton Mo.

19. (a) 11-10-45 (b) H. B. Branninger (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Lobson  
(c) City or town Lecton (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 November day 10th year 1945 hour 7:00 minute 20 A.M.

21. I hereby certify that I attended the deceased from July 4 1944 to Nov. 10 1945 that I last saw him alive on Nov 9 1945 and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral hemorrhage

Due to Arteriosclerosis + Hypertension

Due to /

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations /  
Of autopsy BW

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) (c) Means of injury

23. Signature R. Lee Cooper (M. D. or other)  
Address Warrensburg Mo. Date signed

Duration

5 yr.

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

100

1618

(Licensed Embalmer's Statement on Reverse Side)

DEC 1 1995

**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 W. B. Brumager  
Licensed Embalmer No. 3377  
P. O. Address Sector 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.**