

FILED APR 11 1947

Registration District No. **64**

Primary Registration District No. **4110**

Registrar's No. **11**

1. PLACE OF DEATH:
 (a) County **Chariton**
 (b) City or town **Subsberry**
 (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:
 In this community **practically his lifetime** (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:
 (a) State **Missouri** (b) County **Chariton**
 (c) City or town **Subsberry** (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:

3. (a) PRINT FULL NAME **Steve T. Bennett**
 3. (b) If veteran, name war:
 3. (c) Social Security No.

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **March** day **11** year **1947** hour **2** minute **45** A.M.
21. I hereby certify that I attended the deceased from **March 4** **1947** to **3-11** **1947**
 and that death occurred on the date and hour stated above.
 Immediate cause of death: **Cerebral embolus**

4. Sex **male** **5. Color or race** **white**
6. (a) Single, widowed, married, divorced **married**
(b) Name of husband or wife **Elanor Bennett** **6. (c) Age of husband or wife if alive** **71** years
7. Birth date of deceased **10-31-1865**
 (Month) (Day) (Year)

Due to: **fractured left femur**
 Other conditions: **fract left femur**
 (Include pregnancy within 3 months of death)
 Major findings:
 Of operations:
 Of autopsy:
 Duration:
 Underline the cause to which death should be charged statistically.

8. AGE: Years **81** Months **4** Days **10**
 If less than one day hr. min.

9. Birthplace **Louisville Ky**
 (City, town, or county) (State or foreign country)

10. Usual occupation **farmer**

11. Industry or business **farmer**

12. Name **Thomas Bennett**
13. Birthplace **Ky**
 (City, town, or county) (State or foreign country)

14. Maiden name **Sutcliffe**
15. Birthplace **Ky**
 (City, town, or county) (State or foreign country)

16. (a) Informant **Oscar T. Bennett**
(b) Address **Subsberry Mo**

17. (a) Burial **(b) Date thereof** **3-12-1947**
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Eccles Cemetery**

18. (a) Signature of funeral director **W. A. Thompson**
(b) Address **Subsberry Mo**

19. (a) **3/11/47** **(b)** **W. A. Thompson**
 (Date received local registrar) (Registrar's signature)

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) Means of injury: **O.**

23. Signature **W. A. Thompson** (M. D. or other)
Address **Subsberry Mo** **Date signed** **3/11/47**

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

PHYSICIAN
 Underline the cause to which death should be charged statistically.

RECEIVED

District Health Officer No. 8,

District File Number.....

Date Filed..... 4-10-47

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: Miss Fred A. Thompson

Licensed Embalmer No. 3282

P. O. Address. Madison 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.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. April
Registrar's No. 11

Registration District No. 64

Primary Registration District No. 4110

1. PLACE OF DEATH:

(a) County Chariton
(b) City or town Salisbury
(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 _____ (Specify whether _____)
years, months or days)

3. (a) PRINT FULL NAME

Steve Bennett

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex M Color or race W

6. (a) Single, widowed, married, divorced in

6. (b) Name of husband or wife _____

6. (c) Age of husband or wife if alive _____ years

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

8. AGE: Years 81 Months 4 Days _____ If less than one day _____ hr. _____ min.

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER

12. Name _____

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 _____ (Month) (Day) (Year)
(Burial, cremation, or removal)

(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 _____ 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 statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) accident

(b) Date of occurrence March 4-47

(c) Where did injury occur? in home (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? in home - fell over rug.

While at work? no (Specify type of place) (e) Means of injury fall

23. Signature G.W. Hawkins (M. D. or other)

Address Salisbury, Mo. Date signed 4/15/47

SUPPLEMENTARY

8281