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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED JUN 30 1947

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 21275
Registrar's No. 185

Registration District No. 746

Primary Registration District No. 3026

1. PLACE OF DEATH:
(a) County JACKSON
(b) City or town INDEPENDENCE
(c) Name of hospital or institution:
RESIDENCE 1125 W. VAN HORN
(d) Length of stay: In hospital or institution 26 YEARS
In this community 26 YEARS

2. USUAL RESIDENCE OF DECEASED:
(a) State MISSOURI (b) County JACKSON
(c) City or town INDEPENDENCE
(d) Street No. 1125 W. VAN HORN
(e) Citizen of foreign country? NO

3. (a) PRINT FULL NAME JOSEPH L. BENSON

3. (b) If veteran, name war. NO
3. (c) Social Security No. 492-26-0186

4. Sex MALE
5. Color or race WHITE
6. (a) Single, widowed, married, divorced MARRIED

6. (b) Name of husband or wife SUSAN BENSON
6. (c) Age of husband or wife if alive 3 years 1876

7. Birth date of deceased 8 (Month) 3 (Day) 1876 (Year)

8. AGE: Years 70 Months 10 Days 6

9. Birthplace MAGNOLIA IOWA

10. Usual occupation DENTIST

11. Industry or business DENTISTRY

12. Name BENJ. F. BENSON

13. Birthplace MAGNOLIA IOWA

14. Maiden name MARGARET MAHONEY

15. Birthplace MAGNOLIA IOWA

16. (a) Informant MRS. SUE BENSON

(b) Address 1125 W. VAN HORN

17. (a) BURIAL (b) Date thereof 6-11-47

(c) Place: burial or cremation MOUND GROVE

18. (a) Signature of funeral director H. W. Stahl

(b) Address 815 W. MAPLE AVE.

19. (a) 6-11-47 (b) Registrar's signature

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month JUNE day 9 year 1947 hour 12 minute 30 P.M.

21. I hereby certify that I attended the deceased from June 4th 1947 to June 27th 1947
that I last saw him alive on June 7th 1947
and that death occurred on the date and hour stated above.

Immediate cause of death: Coronary thrombosis
Due to: ancient myocarditis

Other conditions: (Include pregnancy within 3 months of death)

Major findings: Of operations: 947
Of autopsy: Old coronary thrombosis of atherosclerosis

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?
(d) Did injury occur in or about home, on farm, in industrial place, in public place?

23. Signature of physician: J. P. Green
Address: Independence
Date signed: 6-9-47

(Licensed Embalmer's Statement on Reverse Side)

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

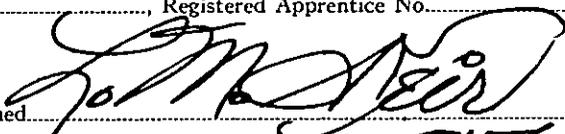
MOTHER FATHER

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

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 

Licensed Embalmer No. 3156

P. O. Address Indep. 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.