

No. 2
-8-43
7-39
X37823

FILED JUL 14 1948

State File No. _____

Registration District No. 116

Primary Registration District No. 3020

Registrar's No. 92

1. PLACE OF DEATH:

(a) County Franklin
(b) City or town Washington Mo
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: St. Francis Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 10 days
In this community 57 years
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Gasconade
(c) City or town Brookland, Bristol
(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

Nettie Bencke

3. (b) If veteran,

name war X

3. (c) Social Security

No. X

4. Sex female

5. Color or race white

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

6. (b) Name of husband or wife X

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

7. Birth date of deceased Jan
(Month)

25
(Day)

1891
(Year)

8. AGE:

Years

Months

Days

If less than one day

57

5

4

hr.

min.

9. Birthplace

Chesterville Mo
(City, town, or county)

Mo
(State or foreign country)

10. Usual occupation

Housewife

11. Industry or business

12. Name

Daniel Dodson

13. Birthplace

Maries Co Mo
(City, town or county)

Mo
(State or foreign country)

14. Maiden name

Helena Pankey

15. Birthplace

Gasconade Co Mo
(City, town, or county)

Mo
(State or foreign country)

16. (a) Informant

Mrs Ethel Miller

(b) Address

Brookland Mo

17. (a)

Brookland
(Burial, cremation, or removal)

(b) Date thereof

7-3-48
(Month) (Day) (Year)

(c) Place: burial or cremation

Gasconade Co Liberty

18. (a) Signature of funeral director

E. H. Meyer

(b) Address

Brookland Mo

19. (a)

7/1/48
(Date received local registrar)

(b)

[Signature]
(Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 30th day June
year 1948 hour 8:40 minute AM

21. I hereby certify that I attended the deceased from June 30, 1948, to June 30, 1948, that I last saw her alive on June 30, 1948 and that death occurred on the date and hour stated above.

Immediate cause of death By bullet wound on left side of back of her head

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) _____

(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) (e) Means of injury _____

23. Signature E. H. Ottman (M.D. or other)

Address Union Mo Date signed 7/30/48

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

MOTHER FATHER

Date Filed 7/23/48
District File Number _____
District Health Officer No. 9,

RECEIVED

JUL 23 1948

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 _____

Stanley E. Meyer

, Registered Apprentice No. 209

working under my personal supervision.

Signed Earl C. Fertig

Licensed Embalmer No. 3385

P. O. Address New Haven

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.

July
92

Registration District No.

116

Primary Registration District No.

3020

Registrar's No.

1. PLACE OF DEATH:

(a) County Franklin
(b) City or town Washington
(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 _____
years, months or days)

3. (a) PRINT FULL NAME

Nette Benche.

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex F

5. Color of race W

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

6. (b) Name of husband or wife _____

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

7. Birth date of deceased _____

Jan 25
(Month) (Day) (Year)

8. AGE:

Years

Months

Days

If less than one day

57

hr. min.

9. Birthplace _____

(City, town, or county)

Mo.
(State or foreign country)

10. Usual occupation _____

11. Industry or business _____

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 _____

(Burial, cremation, or removal)

(Month) (Day) (Year)

(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 _____ Day _____
Year 1942 (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) Homicide ✓
(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) (e) Means of injury _____

23. Signature _____ (M. D. or other) _____

Address _____ Date signed _____

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

SUPPLEMENTARY

S-19097

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30
31
32
33
34
35
36
37
38
39
40
41
42
43
44
45
46
47
48
49
50
51
52
53
54
55
56
57
58
59
60
61
62
63
64
65
66
67
68
69
70
71
72
73
74
75
76
77
78
79
80
81
82
83
84
85
86
87
88
89
90
91
92
93
94
95
96
97
98
99
100