

Registration District No. _____

318

Primary Registration District No. _____

1003

Registrar's No. **6451**

1. PLACE OF DEATH:

(a) County _____
(b) City or town **St. Louis**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Homer G Phillips Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **4 months**
(Specify whether
In this community _____
years, months or days)

3: (a) PRINT FULL NAME **James Bennett**

3. (b) If veteran, name war **World War 1** 3. (c) Social Security No. _____

4. Sex **Male** 5. Color or race **Col.** 6. (a) Single, widowed, married, divorced **Married**
6. (b) Name of husband or wife **Ide** 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased **January 10, 1893**
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
55 6 9 hr. _____ min.

9. Birthplace **Nashville, Tenn.**
(City, town, or county) (State or foreign country)

10. Usual occupation **Laborer**

11. Industry or business _____

12. Name **Unknown**

13. Birthplace **Unknown**
(City, town, or county) (State or foreign country)

14. Maiden name **Unknown**

15. Birthplace **Unknown**
(City, town, or county) (State or foreign country)

16. (a) Informant **Virgin Mitchell**

(b) Address **4115 Delmar**

17. (a) **Burial** (b) Date thereof **7-27-48**
(Burial, cremation, or removal) (Month) (Day) (Year)

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

18. (a) Signature of funeral director **E. B. Young**

(b) Address **1221 N. Grand Blvd.**

19. (a) **JUL 21 1948** (b) **J. F. Bradea**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **67-11**
(c) City or town **St. Louis** **17**
(If outside city or town limits, write "RURAL")
(d) Street No. **2735 Delmar** **9**
(If rural, give location)
(e) Citizen of foreign country? **0** (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **July** day **19**
year **1948** hour **12** minute **10 P. M.**

21. I hereby certify that I attended the deceased from **Mar. 15**, 19 **48**, to **July 19**, 19 **48**;
that I last saw him alive on **July 19**, 19 **48**;
and that death occurred on the date and hour stated above.

Immediate cause of death **1. Brain - Meningitis, chronic 2. Lungs - Abscess; congestion** Duration _____

Due to **Simple Meningitis**
Cause of lung abscess not known
Due **Non-tubercular**

Other conditions: **Kidneys - Pyelonephritis, chronic Non-calculous pyelonephritis**
(Include pregnancy within 3 months of death)

Major findings: _____

Of operations _____

Of autopsy **Yes**

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 **(1)**

23. Signature **Herbert E. Green** (M. D. or other) _____

Address **2601 N Whittier** Date signed **7/21/48**

MOTHER FATHER

AUG 24 1966

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 Herbert J. Vandell

Licensed Embalmer No. 4243

P. O. Address 17 Raymond
Waltham, Mass.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply 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.

Aug

Registration District No.

318

Primary Registration District No.

1043

Registrar's No.

6451

1. PLACE OF DEATH:

(a) County St Louis
 (b) City or town St Louis
(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 years, months or days)

3. (a) PRINT FULL NAME James Bennett

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex M 5. Color or race B 6. (a) Single, widowed, married, divorced M

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

7. Birth date of deceased Jan 10
(Month) (Day) (Year)

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

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

10. Usual occupation Supervisor

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 _____
(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 July 1948
 year _____ hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 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) _____
 (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 _____

SUPPLEMENTARY

S-24103