

Registration District No. 128

Primary Registration District No. 2000

Registrar's No. 769

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

1. PLACE OF DEATH:

(a) County Greene

(b) City or town Springfield,  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:  
O'Reilly VA Hospital  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 11 Months 10 Days  
(Specify whether

In this community Same  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Kentucky

(b) County Hopkins 999  
13

(c) City or town St. Charles  
(If outside city or town limits, write "RURAL")

(d) Street No. 2  
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)  
If yes, name country.

3. (a) PRINT FULL NAME Benjamin R. Carr

3. (b) If veteran, name war World War II

3. (c) Social Security No. Unknown

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month September day 14  
year 1948 hour 6 minute 20A M.

4. Sex Male 2

5. Color or race Negro

6. (a) Single, widowed, married, divorced 2 Widow

6. (b) Name of husband or wife. \_\_\_\_\_

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

7. Birth date of deceased: October 19, 1905  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from October 5, 1947 to September 14, 1948  
that I last saw him alive on September 14, 1948  
and that death occurred on the date and hour stated above.  
Immediate cause of death: Tuberculosis, pulmonary, chronic, reinfection type, far advanced, active Duration \_\_\_\_\_

8. AGE: Years Months Days If less than one day  
42 10 26 hr. \_\_\_\_\_ min.

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

10. Usual occupation Chauffer

11. Industry or business \_\_\_\_\_

MOTHER { 12. Name Unknown 6

13. Birthplace Unknown 1  
(City, town, or county) (State or foreign country)

14. Maiden name Unknown 9

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

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

Major findings: Of operations \_\_\_\_\_

Of autopsy 13B

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

16. (a) Informant VA Records

(b) Address Springfield, Mo.

17. (a) Removal (b) Date thereof 9-16-48  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Springfield, Mo.

18. (a) Signature of funeral director Springfield, Mo.

(b) Address Springfield, Mo.

19. (a) 9-16-48 (b) W. H. Standley, M.D.  
(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 \_\_\_\_\_

23. Signature PAUL L. EISELE (M. D. or other) XXX

Address O'Reilly VA Hospital 9-14-48 Date signed \_\_\_\_\_

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**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.....

*Lewis S. Scharpf*

Licensed Embalmer No. *38021*

P. O. Address.....

*Springfield, 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.**