

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

Registration District No. 318 Primary Registration District No. 1003

1. PLACE OF DEATH:
(a) County _____
(b) City or town St. Louis, Missouri.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
St. Louis City Hospital-Max C. Starkloff
(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 OLIVE BENSON
3. (b) If veteran, name war NONE 3. (c) Social Security No. _____

4. Sex FEMALE 5. Color or race WHITE 6. (a) Single, widowed, married, divorced WIDOW
6. (b) Name of husband or wife LATE E.A. BENSON 6. (c) Age of husband or wife if alive years
7. Birth date of deceased SEP'T. 27 1883
(Month) (Day) (Year)

8. AGE: Years 65 Months 0 Days 26 If less than one day hr. _____ min. _____

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

10. Usual occupation HOUSEWORK

11. Industry or business _____

MOTHER FATHER { 12. Name WILLIAM HOGAN #4
13. Birthplace SCOTLAND
(City, town, or county) (State or foreign country)
14. Maiden name MATHILDA HOFFMAN
15. Birthplace GERMANY
(City, town, or county) (State or foreign country)

16. (a) Informant MRS. EMMA SHEETS

(b) Address 4662 TOWER GROVE PL

17. (a) BURIAL (b) Date thereof 10-26-48
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation VALHALLA CEM.

18. (a) Signature of funeral director KRIEGSHAUSER UND.

(b) Address 4228 So. KINGS HIGHWAY

19. (a) OCT 25 1948 (b) J. B. Luster
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State MO. (b) County aaa
(c) City or town ST. LOUIS 17
(If outside city or town limits, write "RURAL")
(d) Street No. 4398 CHOUTEAU AVE. 9
Memorial 18 (If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct. day 23rd
year 1948 hour 12 minute 15 P.M.

21. I hereby certify that I attended the deceased from 7/24/48
_____, 19____, to Oct. 23rd 1948
that I last saw her alive on Oct. 23rd 1948
and that death occurred on the date and hour stated above.

Immediate cause of death Coronary occlusion
Due to _____
Due to _____
Other conditions _____
(Include pregnancy within 3 months of death)

Major findings: Brain tumor - meningioma
Of operations _____
Of autopsy as above

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. J. Cason, M.D.
1515 Lafayette 10/25/48
Address Date signed

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

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 Richard W. Stoverand
Licensed Embalmer No. 4007
P. O. Address.....

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.