

FILED MAY 11 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **11416**

BIRTH NO. _____ REG. DIST. NO. **10** PRIMARY REG. DIST. NO. **3002** Registrar's No. **68**

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

1. PLACE OF DEATH a. COUNTY AUDRAIN		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE MISSOURI b. COUNTY AUDRAIN	
b. CITY (If outside corporate limits, write RURAL and give town) MEXICO		c. CITY (If outside corporate limits, write RURAL and give township) MEXICO	
d. FULL NAME OF (If not in hospital or institution, give street address or location) 603 West Jackson		d. STREET ADDRESS (If rural, give location) 603 WEST JACKSON	
3. NAME OF DECEASED (Type or Print) a. (First) MARY		c. (Last) BENNETT	
b. (Middle) _____		4. DATE OF DEATH (Month) (Day) (Year) 4 29, 1949	
5. SEX Female	6. COLOR OR RACE NEGRO	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) WIDOWED	8. DATE OF BIRTH OCT. 25 - 1864
9. AGE (In years - last birthday) 84	IF UNDER 1 YEAR Months 6 Days 4	IF UNDER 24 HRS. Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) DOMESTIC	10b. KIND OF BUSINESS OR INDUSTRY _____	11. BIRTHPLACE (State or foreign country) McCRACKEN COUNTY, Ky /	
12. CITIZEN OF WHAT COUNTRY? U. S. A			
13a. FATHER'S NAME WILLIAM ELLIS		13b. MOTHER'S MAIDEN NAME UNKNOWN	
14. NAME OF HUSBAND OR WIFE WILLIAM BENNETT			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT'S SIGNATURE OR NAME EDNA PIERCE		ADDRESS 603 WEST JACKSON Mexico Mo	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Chronic Myocarditis ANTECEDENT CAUSES: Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Cardio vascular disease DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT SUICIDE HOMICIDE (Specify) _____	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? _____	
22. I hereby certify that I attended the deceased from Oct 18, 1949 , to April 28, 1949 , that I last saw the deceased alive on Apr 28, 1949 , and that death occurred at 9:30 a.m. , from the causes and on the date stated above.			
23a. SIGNATURE Charles L. Garcia, M.D.		23b. ADDRESS Mexico Mo	
23c. DATE SIGNED Apr 30 49			
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	24b. DATE 4-30-1949	24c. NAME OF CEMETERY OR CREMATORY THISLEWOOD	24d. LOCATION (City, town, or county) (State) MOUNDS ILLINOIS
DATE REC'D BY LOCAL REG. Apr 30-1949	REGISTRAR'S SIGNATURE Blanche Neely	25. FUNERAL DIRECTOR'S SIGNATURE J. L. OWENS, MEXICO, MO	

FEB 27 1950

RECEIVED
District Health Officer N.
District File Number 5-49
Date Filed MAY 10 1949

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 _____

Student Embalmer No. _____

working under my personal supervision.

Student _____
Student Embalmer

Signed El. Bell

Licensed Embalmer No. 2130

P. O. Address Fulton, 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.