

FILED DEC 1 1949

STANDARD CERTIFICATE OF DEATH

38509

State File No. 10031

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. _____

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Montgomery	
b. CITY (If outside corporate limits, write BURIAL and give township) St. Louis Mo		c. CITY (If outside corporate limits, write BURIAL and give township) New Florence Mo	
c. LENGTH OF STAY (In this place) 10		d. STREET ADDRESS (If rural, give location) NR = F. one	
d. FULL NAME OF HOSPITAL OR INSTITUTION Christian Hospital St. Louis			

3. NAME OF DECEASED (Type or Print) Stella	a. (First)	b. (Middle)	c. (Last) Benny	4. DATE OF DEATH (Month) (Day) (Year) 11 22 49
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5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH 10-22-1883	9. AGE (In years last birthday) 66	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	11. BIRTHPLACE (State or foreign country) Montgomery Co D	12. CITIZEN OF WHAT COUNTRY? USA
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13a. FATHER'S NAME William P. Christian	13b. MOTHER'S MAIDEN NAME Martha Ann Clark	14. NAME OF HUSBAND OR WIFE Charles A. Benny
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) ✓	16. SOCIAL SECURITY NO. ✓	17. INFORMANT'S SIGNATURE OR NAME Charles A. Benny

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		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)	Cerebral Embolism Left hemiplegia 3 days		
ANTECEDENT CAUSES	DUE TO (b) Hypertensive Cv. Disease		
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.	DUE TO (c) Benign Thyroid gaiter diffuse 3 yrs +		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	Thyroid gaiter diffuse		3 yrs +
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) 930
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? H221

22. I hereby certify that I attended the deceased from 11-20, 1949, to 11-22, 1949, that I last saw the deceased alive on 11-21, 1949, and that death occurred at 7:25 a.m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) John L. Kennedy M.D.C.M.	23b. ADDRESS 508 70 Grand Ave	23c. DATE SIGNED 11-22-49
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 11-24-49	24c. NAME OF CEMETERY OR CREMATORY St. Louis	24d. LOCATION (City, town, or county) (State) New Florence Mo
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DATE REC'D BY LOCAL OFF. NOV 22 1949	REGISTRAR'S SIGNATURE J. B. Faoster	25. FUNERAL DIRECTOR'S SIGNATURE Clara A. Jones	ADDRESS Bellflower Mo
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WRITE PLAINLY—USING 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 _____

me

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed _____

Clarence H. Jones

Licensed Embalmer No. *2978*

P. O. Address *Belleflower Inc*

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.