

MISSOURI DIVISION OF HEALTH  
STANDARD CERTIFICATE OF DEATH

34584

State File No. \_\_\_\_\_  
Registrar's No. 9004

Registration District No. 2 **318** Primary Registration District 1003

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 Ex Route City Hospital  
(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 CAROLINE - BENISH  
3. (b) If veteran, \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_  
name war \_\_\_\_\_

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Married  
6. (b) Name of husband or wife Fred 6. (c) Age of husband or wife if alive 70 years  
7. Birth date of deceased Unknown  
(Month) (Day) (Year)

8. AGE: Years abt - 75 Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day  
hr. \_\_\_\_\_ min. \_\_\_\_\_

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

10. Usual occupation Housewife

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 Fred Benish

(b) Address 2520 A De Kalb

17. (a) \_\_\_\_\_ (b) Date thereof 6  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Anatomical Board Oct 24 1950

18. (a) Signature of funeral director Bowdoin

(b) Address 1104 W. ...

19. (a) Oct 24 1950 (b) J. B. ...  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County 2239  
(c) City or town St. Louis  
(If outside city or town limits, write "RURAL")  
(d) Street No. 2520 A De Kalb  
(If rural, give location)  
(e) Citizen of foreign country? U.S.A. (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 10 day 4  
year 1950 hour 1:00 minute PM

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 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 \_\_\_\_\_  
Coronary Occlusion  
Due to Chronic Nephrotic  
Due to Nephrotic  
Other conditions \_\_\_\_\_  
(Includes 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: 592X  
(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? \_\_\_\_\_

(Specify type of place) 3  
While at work? \_\_\_\_\_ (e) Means of injury \_\_\_\_\_  
23. Signature Joseph H. ... (M. D. or other) \_\_\_\_\_  
Address 1300 Clark Date signed \_\_\_\_\_

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

MOTHER FATHER

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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.....

Licensed Embalmer No.....

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.**