

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

17817

State File No.

FILED JUN 15 1951

BIRTH NO.		REG. DIST. NO. 318		PRIMARY REG. DIST. NO. 1003		Registrar's No. 5101	
1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		c. LENGTH OF STAY (in this place)		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		2109	
d. FULL NAME OF HOSPITAL OR INSTITUTION 4145 Grove Ave				d. STREET ADDRESS (If rural, give location) 4145 Grove Ave			
3. NAME OF DECEASED (Type or Print) a. (First) John E. b. (Middle) Benne c. (Last)			4. DATE OF DEATH (Month) (Day) (Year) June 1st, 1951				
5. SEX male	6. COLOR OR RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married	8. DATE OF BIRTH Nov 9th, 1886	9. AGE (In years last birthday) 64	IF UNDER 1 YEAR Months Days	IF UNDER 4 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Stationary Fireman		10b. KIND OF BUSINESS OR INDUSTRY Dairy		11. BIRTHPLACE (State or foreign country) St. Louis Co		12. CITIZEN OF WHAT COUNTRY?	
13a. FATHER'S NAME William Benne		13b. MOTHER'S MAIDEN NAME Lesette Geiseking		14. NAME OF HUSBAND OR WIFE Marie Benne			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 495-18-1311		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Marie Benne 4145 Grove Ave.,			
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, asphyxia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral hemorrhage ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Arterio-sclerosis DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Chronic myocarditis					INTERVAL BETWEEN ONSET AND DEATH 1 day	
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) evening 7:30		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? fall			
22. I hereby certify that I attended the deceased from May 12, 1951 , to June 1, 1951 , that I last saw the deceased alive on June 1, 1951 , and that death occurred at 2:55 P.M. (from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) Walter J. Mellis M.A.				23b. ADDRESS 3825 N. 20th St.		23c. DATE SIGNED June 2 '51	
24a. BURIAL, CREMATION, REMOVAL (Specify) burial		24b. DATE 6/4/51	24c. NAME OF CEMETERY OR CREMATORY Salem Luth. Cemetery		24d. LOCATION (City, town, or county) (State) St. Louis Co., Mo.		
DATE REC'D BY LOCAL REG. JUN 3 1951		REGISTRAR'S SIGNATURE J. B. Parson		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Diedrich Funeral Home 8319 Hallsferry			

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 _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed

John J. Haines

Licensed Embalmer No. *4108*

P. O. Address *St. Louis 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.