

THE DIVISION OF HEALTH OF THE STATE OF MISSOURI
STANDARD CERTIFICATE OF DEATH

31280

State File No.

SEP 29 1952

BIRTH NO. _____ REG. DIST. NO. 120 PRIMARY REG. DIST. NO. 497 Registrar's No. 70

1. PLACE OF DEATH
a. COUNTY Gentry

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE MO. b. COUNTY Gentry

b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Stanberry c. LENGTH OF STAY (In township) 3 years

c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Stanberry 03

d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Harmony Hill Rest Haven

d. STREET ADDRESS (If rural, give location) N. Alanthus Avenue

3. NAME OF DECEASED (Type or Print)
a. (First) Mrs. Blanche b. (Middle) Lucile c. (Last) Benight

4. DATE OF DEATH (Month) (Day) (Year)
Sept 23 1952

5. SEX female 6. COLOR OR RACE white 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married

8. DATE OF BIRTH Feb 12 1910 9. AGE (In years last birthday) 42 IF UNDER 1 YEAR: Months _____ Days _____ IF UNDER 14 HRS. Hours _____ Min. _____

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife

10b. KIND OF BUSINESS OR INDUSTRY at home

11. BIRTHPLACE (State or foreign country) Kearney Nebraska 12. CITIZEN OF WHAT COUNTRY? U.S.A

13a. FATHER'S NAME Joseph Kauer 13b. MOTHER'S MAIDEN NAME unknown 14. NAME OF HUSBAND OR WIFE Ray Benight

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 542-326141

17. INFORMANT'S SIGNATURE OR NAME Mr. Ray Benight ADDRESS Stanberry, Mo.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Hodgkins' Disease INTERVAL BETWEEN ONSET AND DEATH 2 yrs +

ANTECEDENT CAUSES
Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) _____
DUE TO (c) _____

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. None

19a. DATE OF OPERATION 10 Feb 1951 19b. MAJOR FINDINGS OF OPERATION Hodgkin's Disease 20. AUTOPSY? YES NO

21a. ACCIDENT (Specify) SUICIDE 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 NOT WHILE AT WORK 21f. HOW DID INJURY OCCUR? _____

22. I hereby certify that I attended the deceased from 1 Sept 1952 to 23 Sept 1952, that I last saw the deceased alive on 23 Sept 1952, and that death occurred at 9:30 a.m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Clair L. Carlson M.D. 23b. ADDRESS Stanberry, Mo. 23c. DATE SIGNED 24 Sept 52

24a. BURIAL, CREMATION, REMOVAL (Specify) burial 24b. DATE 9/29/52 24c. NAME OF CEMETERY OR CREMATORY Riverside 24d. LOCATION (City, town, or county) (State) Albany, Oregon

DATE REC'D BY LOCAL REG. Sept 25 52 REGISTRAR'S SIGNATURE Maude Williams 25. FUNERAL DIRECTOR'S SIGNATURE Fate H. Phillips ADDRESS Stanberry Mo

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 _____

Leroy F. Phillips

Licensed Embalmer No. 1898

P. O. Address Starkley, Me

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.