

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

22144

State File No.

FILED JUL 13 1953 BIRTH NO. ... REG. DIST. NO. 187 PRIMARY REG. DIST. NO. 3040 Registrar's No. 95

1. PLACE OF DEATH a. COUNTY Livingston		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Livingston	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Chillicothe		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Chillicothe	
c. LENGTH OF STAY (In this place) 10 years		0592 1	
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION City Hospital		d. STREET ADDRESS (If rural, give location) 812 Calhoun Street	

3. NAME OF DECEASED (Type or Print)	a. (First) Asmus	b. (Middle) Carl	c. (Last) Benning	4. DATE OF DEATH	(Month) July	(Day) 5	(Year) 1953
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5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Divorced	8. DATE OF BIRTH January 17, 1892	9. AGE (In years last birthday) 61	IF UNDER 1 YEAR Months	IF UNDER 1 YEAR Days	IF UNDER 1 HRS. Hours	IF UNDER 1 HRS. Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Velista, Iowa	12. CITIZEN OF WHAT COUNTRY? U.S.
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13a. FATHER'S NAME William Benning	13b. MOTHER'S MAIDEN NAME No Record	14. NAME OF HUSBAND OR WIFE No Record
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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. 489-36-0309	17. INFORMANT'S SIGNATURE OR NAME C. A. Benning; Des Moines, Iowa.	ADDRESS 3017 East Douglas
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH 30 min.
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) acute coronary occlusion		ANTECEDENT CAUSES		
*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.		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.		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION 4201	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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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)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from July 5, 1953, to July 5, 1953, that I last saw the deceased alive on July 5, 1953, and that death occurred at 1 A. M., from the causes and on the date stated above.

23a. SIGNATURE Joseph A. Gale M.D. (Degree or title)	23b. ADDRESS Chillicothe, Mo.	23c. DATE SIGNED 7-6-53
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 7-10-53	24c. NAME OF CEMETERY OR CREMATORY Wayne	24d. LOCATION (City, town, or county) (State) Wayne, Nebraska
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DATE REC'D BY LOCAL REG. July 6-53	REGISTRAR'S SIGNATURE Frances B. Neill	25. FUNERAL DIRECTOR'S SIGNATURE Norman Funeral Home; Chillicothe, Mo.	ADDRESS
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

0.300
0.48
92
0

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 Elton J. Norman

Licensed Embalmer No. 4036

P. O. Address Chillicothe, Missouri.

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.