

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

35128

FILED OCT 26 1954

State File No. \_\_\_\_\_  
Registrar's No. **8544**

BIRTH NO. _____		REG. DIST. NO. <b>318</b>		PRIMARY REG. DIST. NO. <b>1003</b>		State File No. _____		Registrar's No. <b>8544</b>		
1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Missouri</b> b. COUNTY						
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>St. Louis, Mo.</b>		c. LENGTH OF STAY (in this place) <b>Years</b>		c. CITY OR TOWN <b>St. Louis</b>		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>				
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>4259a Kossuth Avenue,</b>				e. STREET ADDRESS (If rural, give location) <b>10 4259a Kossuth Avenue</b>		<b>21090</b>				
3. NAME OF DECEASED a. (First) <b>George</b> (Type or Print)			b. (Middle) <b>M.</b>		c. (Last) <b>Benoist</b>		4. DATE OF DEATH (Month) (Day) (Year) <b>September 17, 1954</b>			
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Widowed</b>		8. DATE OF BIRTH <b>Dec. 25, 1900</b>		9. AGE (In years last birthday) <b>53</b>	IF UNDER 1 YEAR Months	IF UNDER 1 YEAR Days	IF UNDER 1 HRS. Hours	IF UNDER 1 HRS. Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Dock Hand</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Schien Truck Lines</b>		11. BIRTHPLACE (City and State or Foreign Country) <b>Florissant, Missouri.</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13a. FATHER'S NAME <b>Leon Benoist</b>			13b. MOTHER'S MAIDEN NAME <b>Mary Barteau</b>			14. NAME OF HUSBAND OR WIFE <b>Mrs. Margaret L. Benoist,</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <b>Mrs Jack Di Carlo, 4259a Kossuth Ave.</b>						
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, asthenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Carcinoma of lung</b>  ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.  DUE TO (b) _____  DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <del>1 month</del> <b>4 months</b>		
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION <b>out cell carcinoma of lung. May 54 DePaul Hosp</b>						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)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR <b>163x</b>						
22. I hereby certify that I attended the deceased from <b>5-14-1954</b> , to <b>9-17-1954</b> , that I last saw the deceased alive on <b>9-17-1954</b> , and that death occurred at <b>11:00A</b> m., from the causes and on the date stated above.										
23a. SIGNATURE (Name or title) <b>Wayne D. Smith M.D.</b>				23b. ADDRESS <b>2739 No. Grand</b>			23c. DATE SIGNED <b>9-17-54</b>			
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		24b. DATE <b>9-20-1954</b>	24c. NAME OF CEMETERY OR CREMATORY <b>Lake Charles Cemetery</b>		24d. LOCATION (City, town, or county) (State) <b>St. Louis, County, Mo.</b>					
DATE REC'D BY LOCAL REG. <b>SEP 18 1954</b>		REGISTRAR'S SIGNATURE <b>J. Carl Smith M.D.</b>			25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>Math. Hermann &amp; Son, Inc. 2161 E. Fair Ave.</b>					

S.P. (Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING UNFAADING BLACK INK—MAKE A PERMANENT RECORD

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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 ....., Student Embalmer No. .... working under my personal supervision..

Student.....  
Signature of Student Embalmer

Signed *Clement M. Gray*

Licensed Embalmer No. *373*

P. O. Address *H. L. ...*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.