

FILED NOV 25 1955

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 37766

| | | | | | | | | | |
|---|--|---|--|--|--|---|--|--|--|
| BIRTH NO. _____ | | REG. DIST. NO. 278 | | PRIMARY REG. DIST. NO. 3955 | | Registrar's No. 126 | | | |
| 1. PLACE OF DEATH a. COUNTY Pike | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Pike | | | | | |
| b. CITY OR TOWN Ashburn | | c. LENGTH OF STAY (in this place) 49 ym | | c. CITY OR TOWN Ashburn | | d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | | | |
| d. FULL NAME OF HOSPITAL OR INSTITUTION _____ | | | | STREET ADDRESS (If rural, give location) Sact River Township 0820 | | | | | |
| 3. NAME OF DECEASED (Type or Print) a. (First) JOHN | | b. (Middle) ARCH | | c. (Last) BENN | | 4. DATE OF DEATH (Month) (Day) (Year) Nov. 6-1955 | | | |
| 5. SEX M | | 6. COLOR OR RACE white | | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <input checked="" type="checkbox"/> widowed | | 8. DATE OF BIRTH Mar. 12-1915 | | | |
| 9. AGE (In years last birthday) 80 | | IF UNDER 1 YEAR Months | | IF UNDER 24 HRS. Days | | Hours Min. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer | | 10b. KIND OF BUSINESS OR INDUSTRY _____ | | 11. BIRTHPLACE (City and State or Foreign Country) Frankford, Mo. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | |
| 13a. FATHER'S NAME GEORGE BENN | | 13b. MOTHER'S MAIDEN NAME REBECCA JANE LAMBERSON | | 14. NAME OF HUSBAND OR WIFE JESSIE BENN | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no | | 16. SOCIAL SECURITY NO. 70 | | 17. INFORMANT'S SIGNATURE OR NAME Mrs. Paula Weese Ashburn, Mo. ADDRESS _____ | | | | | |
| 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, asthma, etc. It means the disease, injury, or complication which caused death. | | MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Diabetic Gangrene throat left kidney. Abdominal poisoning. Diabetes. ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Diabetes. DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. 260X | | | | | | INTERVAL BETWEEN ONSET AND DEATH _____ | |
| 19a. DATE OF OPERATION _____ | | 19b. MAJOR FINDINGS OF OPERATION _____ | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input 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) _____ m. | | 21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21f. HOW DID INJURY OCCUR? _____ | | | | | |
| 22. I hereby certify that I attended the deceased from May 19 1955, to Nov. 1955, that I last saw the deceased alive on Nov. 5, 1955, and that death occurred at 10:30 p.m., from the causes and on the date stated above. | | | | | | | | | |
| 23a. SIGNATURE E. P. Hansen D.O. (Degree or title) | | | | 23b. ADDRESS Frankford, Mo. | | 23c. DATE SIGNED Mar 9 1955 | | | |
| 24a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 24b. DATE Nov. 9-1955 | | 24c. NAME OF CEMETERY OR CREMATORY Fairview Cem. | | 24d. LOCATION (City, town, or county) Grass Creek (Rural) Mo. | | | |
| DATE REC'D BY LOCAL REG. Nov 16, 1955 | | REGISTRAR'S SIGNATURE Bernice Callier 374 | | 25. FUNERAL DIRECTOR'S SIGNATURE J. J. Mequon | | ADDRESS Frankford Mo. | | | |

(Licensed Embalmer's Statement on Reverse Side)

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.....
Signature of Student Embalmer

Signed *Jane Fields Megow*.....

Licensed Embalmer No. *409*

P. O. Address *Malfr*

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.