

FILED MAR 26 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

11909

STATE FILE NUMBER

Registration District No. 379

Primary Registration District No. 4553

Registrar's No. 202

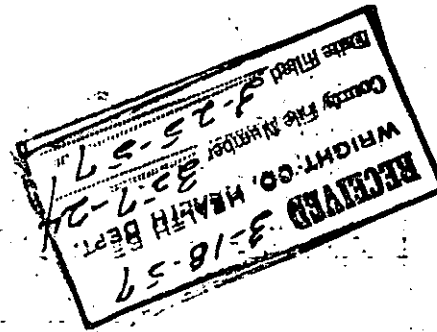
1. PLACE OF DEATH a. COUNTY <u>Wright Co Mo</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo</u> b. CITY OR TOWN <u>Marshfield Mo</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Marshfield</u> c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Marshfield Hospital</u>		c. CITY OR TOWN <u>Marshfield Mo</u> d. STREET ADDRESS <u>RFD 3</u>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Marshfield Hospital</u>		d. STREET ADDRESS <u>RFD 3</u>	
3. NAME OF DECEASED (Type or print) <u>DEIRIEH</u> First <u>DEF</u> Middle <u>BENNETT</u> Last		4. DATE OF DEATH <u>3-10-57</u> Month <u>3</u> Day <u>10</u> Year <u>57</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐	8. DATE OF BIRTH <u>JUNE 5-1934</u> 26
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farming</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>	
13. FATHER'S NAME <u>THOMAS BENNETT</u>		14. MOTHER'S MAIDEN NAME <u>MARY ANN CARPENTER</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>500.382565</u>	
17. INFORMANT <u>Thomas Bennett</u> Address <u>Marshfield Mo 3</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Sepsis Caused by Bronchopneumonia</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Influenza (old)</u> DUE TO (c) <u></u>	
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒		INTERVAL BETWEEN ONSET AND DEATH <u>10 days</u> <u>20 days</u>	
20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY: Hour <u></u> Month <u></u> Day <u></u> Year <u></u> a. m. <u></u> p. m. <u></u>		20d. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	
20e. CITY, TOWN, OR LOCATION		COUNTY STATE	
21. I attended the deceased from <u>Feb-26-57</u> to <u>March 10-57</u> and last saw <u>him</u> alive on <u>3/10/57</u>		Death occurred at: <u>815A</u> m on the date stated above; and to the best of my knowledge, from the causes stated.	
22a. SIGNATURE <u>R Lee</u> (Degree or title) <u>Dr.</u>		22b. ADDRESS <u>2 Seymour</u>	
22c. DATE SIGNED <u>3/13/57</u>		23a. NAME OF CEMETERY OR CREMATORY <u>DePue</u>	
23b. DATE <u>3-14-57</u>		23c. LOCATION (City, town, or county) <u>Wright Co Mo</u> (State)	
24. FUNERAL DIRECTOR <u>Robert Bergman</u> ADDRESS <u>Mo</u>		25. DATE RECD. BY LOCAL REG. <u>3/22/57</u>	
26. REGISTRAR'S SIGNATURE <u>Ann Perkins</u>			

MEDICAL CERTIFICATION

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

securing the medical certification in the specific manner required by 193.140 works 1949.
Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.

(Licensed Embalmer's Statement on Reverse Side)



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 Max L Miller

Licensed Embalmer No. 472

P. O. Address Maryfield, Ill.

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.