

Health, Welfare, Public Service
300
-56
Diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.
USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

19877

FILED MAY 22 1957

STATE FILE NUMBER

Registration District No. 366 Primary Registration District No. 6241 Registrar's No. 43

1. PLACE OF DEATH a. COUNTY <u>Washington</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Washington</u> ✓	
b. CITY (If outside corporate limits, give TOWNSHIP only) Inside Limits OR TOWN <u>Rural Bretton Twp.</u> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		c. CITY OR TOWN <u>1100</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Man Patou</u> Length of stay in 1b <u>6 yrs</u>		d. STREET ADDRESS (If outside, give location) <u>Man Patou</u> Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <u>Ada</u> Middle <u>Belle</u> Last <u>Benson</u>			4. DATE OF DEATH Month <u>May</u> Day <u>19</u> Year <u>1957</u>		
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5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 9 1876</u>	9. AGE (In years last birthday) <u>81</u>	IF UNDER 1 YEAR Months <u>10</u> Days <u>10</u> Hours <u>10</u> Min. <u></u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House work</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>	11. BIRTHPLACE (City and state or country) <u>Washington Co. Mo.</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
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13. FATHER'S NAME <u>William Hays</u>	14. MOTHER'S MAIDEN NAME <u>Martha Rose</u>
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)	16. SOCIAL SECURITY NO. <u></u>	17. INFORMANT <u>Mildred Jenkins Patou Mo.</u> Address
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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>Cerebral Thrombosis following Bacterial Endocarditis and Labor pneumonia</u>		INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u></u>	
	DUE TO (c) <u></u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u></u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>

20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u></u>
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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. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) <u></u>	20f. CITY, TOWN, OR LOCATION <u></u> COUNTY <u></u> STATE <u></u>
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21. I attended the deceased from <u>April 1/57 to May 19/57</u> and last saw <u>her</u> alive on <u>May 18/57</u> Death occurred at <u>11:0-10 A</u> in on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <u>L. F. Presswell M.D.</u>	22b. ADDRESS <u>Patou Mo.</u>	22c. DATE SIGNED <u>5/20/57</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>5-21-57</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Patou Masonic Ch.</u>	23d. LOCATION (City, town, or county) (State) <u>Patou Mo.</u>
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24. FUNERAL DIRECTOR <u>Mr. Luther Sparks Patou Mo.</u> ADDRESS	25. DATE RECD. BY LOCAL REG. <u>5/20/57</u>	26. REGISTRAR'S SIGNATURE <u>Helmut Rudal</u>
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(Licensed Embalmer's Statement on Reverse Side)

Dr. Presswell

RECEIVED

MAY 21 1957

WASH. COUNTY HEALTH DEPT.

File No. _____

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 Murphy L. Sparks

Licensed Embalmer No. H-2

P. O. Address W. Lat. Rm.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (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.