

Health, Welfare Public Service

300 -56

ALL diseases in Part I must be carefully related. Caregiver cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
L. M. Tillman, M.D.

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

FILED AUG 1 - 1957

24408  
STATE FILE NUMBER 3281

Registration District No. 101 Primary Registration District No. 1012 Registrar's No.

1. PLACE OF DEATH a. COUNTY <b>Jackson</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Jackson</b>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Kansas City</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <b>Kansas City</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Gen. Hosp #2</b>		Length of stay in lb <b>15 years</b>		STREET ADDRESS <b>2326 Chestnut</b>		(If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>LEROY BENNETT</b>				4. DATE OF DEATH <b>July 14, 1957</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Negro</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Sept. 19, 1921</b>	
9. AGE (In years last birthday) <b>35</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>cafateria work</b>		100. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <b>Doddridge, Ark.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>cafateria work</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <b>Doddridge, Ark.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Jefferson Bennett</b>				14. MOTHER'S MAIDEN NAME <b>Teresa Steward</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>yes 8/16/40</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>		17. INFORMANT Address <b>Theresa Stucky 2326 Chestnut K.C.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary Congestion</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <b>Coronary Artery Sclerosis</b> DUE TO (c) <b>Arteriosclerosis</b>						INTERVAL BETWEEN ONSET AND DEATH <b>4201</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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.)				
20c. TIME OF INJURY Hour <b>   </b> Month, Day, Year a. m. <b>   </b> p. m. <b>   </b>							
20d. INJURY OCCURRED WHILE AT <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.)		20f. CITY, TOWN, OR LOCATION		COUNTY STATE	
21. I attended the deceased from _____ to _____ and last saw her alive on _____ Death occurred at _____ m on the date stated above; and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE <b>Deputy Coroner</b>				22b. ADDRESS <b>1618 Lydia Ave</b>		22c. DATE SIGNED <b>7/14/57</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <b>7/19/57</b>		23c. NAME OF CEMETERY OR CREMATORY <b>National Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>St. Louis, Missouri</b>	
24. FUNERAL DIRECTOR <b>Mrs. Meek's Mortuary K. C. Mo.</b>			25. DATE RECD. BY LOCAL REG. <b>7-15-57</b>		26. REGISTRAR'S SIGNATURE <b>Norma Winshall</b>		

(Licensed Embalmer's Statement on Reverse Side)

MS  
APR 15 1959

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 *Millard B. Pasko* .....

Licensed Embalmer No. *50*

P. O. Address *R.C.*

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.