

Health,  
Welfare  
Public  
Service

FILED JUL 23 1957

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

STATE FILE NUMBER 27327

Registration District No. 378 Primary Registration District No. 6282 Registrar's No. 277

Doctor, coroner, etc., must use only standard nomenclature in item 18. No symptoms will be listed. All 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

1. PLACE OF DEATH a. COUNTY <b>WRIGHT</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MO.</b> b. COUNTY <b>WRIGHT</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>CLARK</b> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		c. CITY OR TOWN <b>MACOMB</b> 1140 Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>MACOMB R. R. 15 YEARS</b> Length of stay in lb		d. STREET ADDRESS (If outside, give location) <b>RT. 1</b> Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>William Isaac Bennett</b> First Middle Last		4. DATE OF DEATH <b>June 30 1957</b> Month Day Year	
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>AUG. 24, 1874</b> 82
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>FARMER</b>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) <b>82</b> IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
11. BIRTHPLACE (City and state or country) <b>MACOMB MO.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.-A.</b>	
13. FATHER'S NAME <b>Charley Bennett</b>		14. MOTHER'S MAIDEN NAME <b>DEACY GRAY</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>NONE</b>	
17. INFORMANT <b>Smith Bennett</b> Address <b>Norwood Mo.</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>Arteriosclerosis Heart disease</b> DUE TO (b) <b>Hypertension, Arteriosclerosis</b> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH <b>Not known</b> <b>Not known</b>
19. WAS AUTOPSY PERFORMED? <b>NO</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>4200</b>	
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20c. TIME OF INJURY Hour Month, Day, Year a. m. p. m.		
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.)	20f. CITY, TOWN, OR LOCATION	COUNTY STATE
21. I attended the deceased from <b>Nov 1, 1957</b> , to <b>June 30 1957</b> and last saw her alive on <b>June 27-1957</b> Death occurred at <b>9:15 A.M.</b> on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <b>Max Miller M.D.</b>		22b. ADDRESS <b>Mountain Grove Mo.</b>	22c. DATE SIGNED <b>7-16-57</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE <b>July 2, 1957</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Ashley</b>	23d. LOCATION (City, town, or county) (State) <b>WRIGHT County Mo.</b>
24. FUNERAL DIRECTOR ADDRESS <b>Max Miller Mountain Mo.</b>		25. DATE RECD. BY LOCAL REG. <b>7/15/57</b>	26. REGISTRAR'S SIGNATURE <b>Star Rushing</b>

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED  
4-20-59  
WRIGHT CO. HEALTH DEPT.  
County File Number  
7-20-59  
Date Filed

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. *47*

P. O. Address: *Manassas*

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.