

Health, Welfare, Public Service

FILED OCT 14 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

30903

STATE LICENSE NUMBER

Registration District No. 42 Primary Registration District No. 1000 Registrar's No. 1073

1. PLACE OF DEATH a. COUNTY Buchanan		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Buchanan	
b. CITY (If outside corporate limits, give TOWNSHIP only) St. Joseph		c. CITY OR TOWN St. Joseph <i>117</i>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 104-1/2 No. 2nd St.		d. STREET ADDRESS 104-1/2 No. 2nd St.	
Length of stay in lb 4yrs		Reside on Form Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) BENJAMIN F HENDEL			4. DATE OF DEATH Month Sept. Day 30 Year 1957		
---	--	--	---	--	--

5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH Oct. 20, 1898	9. AGE (In years last birthday) 58	10. FUNDER 1 YEAR Months Days	11. IF UNDER 24 HRS. Hours Min.
--------------------	-------------------------------	---	---------------------------------------	---	----------------------------------	------------------------------------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer	10b. KIND OF BUSINESS OR INDUSTRY Railroad	11. BIRTHPLACE (City and state or country) Afton Missouri	12. CITIZEN OF WHAT COUNTRY? USA
--	---	--	---

13a. FATHER'S NAME Paul Hendel	13b. MOTHER'S MAIDEN NAME Anna Sontag	14. NAME OF HUSBAND OR WIFE Divorced
---------------------------------------	--	---

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	16. SOCIAL SECURITY NO. 498-01-8669	17. INFORMANT Max Handel	Address House Springs, Mo.
---	--	---------------------------------	-----------------------------------

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Strangulation		INTERVAL BETWEEN ONSET AND DEATH Ukn.	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) Hanging by neck		Ukn.
	DUE TO (c)		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 974x		19. WAS AUTOPSY PERFORMED? 2 YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	

20a. ACCIDENT <input type="checkbox"/> SUICIDE <input checked="" type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) Heavy new rope around neck and attached by other end to steam pipe.
20c. TIME OF INJURY Hour ? Month, Day, Year Sept 30 57 a.m. p.m.	Time between midnight Sept. 30 and 2:40 A.M. Sept 30 57

20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Colonial Hotel room	20f. CITY, TOWN, OR LOCATION St. Joseph	COUNTY Buchanan	STATE MO
21. I attended the deceased from brained below and last saw him alive on Sept 30 1957 Death occurred at App. 12:00 A.M. to 2:40 A.M. m on the date stated above; and to the best of my knowledge, from the causes stated.				

22a. SIGNATURE Emelunayr D. Coronov (Degree or title)	22b. ADDRESS 2147 Kirkpatrick Building St. Joseph 8, MO	22c. DATE SIGNED Oct 8-57
--	--	----------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE October, 2, 57	23c. NAME OF CEMETERY OR CREMATORY St. Martin Cemetary	23d. LOCATION (City, town, or county) (State) High Ridge Missouri
--	---------------------------------	---	--

24. FUNERAL DIRECTOR Home Funeral Home	ADDRESS St. Joseph, Mo.	25. DATE RECD. BY LOCAL REG. Oct 11, 1957	26. REGISTRAR'S SIGNATURE Mrs. Robert Fulton
---	--------------------------------	--	---

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

NOV 15 1951

NOV 14 1951

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 Charles E. Bennett

Licensed Embalmer No. 4627

P. O. Address St. Joseph, Mo.

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.