

Health,
& Welfare
S. Public
th Service

FILED OCT 21 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

STATE FILE NUMBER

37995
9518

Registration District No. 318 Primary Registration District No. 1003

Registrar's No.

S. 300
v. 1-57

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.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MISSOURI</u> COUNTY			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>ST. LOUIS Mo</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>ST. LOUIS</u>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>BETHESDA Hosp.</u>		Length of stay in 1b <u>4 DAYS</u>		d. STREET ADDRESS (If outside, give location) <u>2171 1/2 3926 SHENANDOAH</u>	
3. NAME OF DECEASED (Type or print) First <u>BENJAMIN</u> Middle Last <u>PONDER JR.</u>			4. DATE OF DEATH Month <u>OCT.</u> Day <u>9</u> Year <u>1957</u>		
5. SEX <u>MALE</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>AUG. 15 1888</u>		9. AGE (In years last birthday) <u>69</u> IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN FARM</u>	11. BIRTHPLACE (City and state or country) <u>APPLE CREEK Mo.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>
13a. FATHER'S NAME <u>LOUIS PONDER</u>		13b. MOTHER'S MAIDEN NAME <u>MARY KIRN</u>		14. NAME OF HUSBAND OR WIFE <u>FLORENCE PONDER</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>49-32-5942</u>	17. INFORMANT Address <u>FLORENCE PONDER 3926 Shenandoah</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>(1) Acute necrotic Pancreatitis</u>					INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause lost. DUE TO (b) <u>acute cholelithiasis + cholecystitis</u>					<u>10-15 days</u>
DUE TO (c) <u>(2) Broncho pneumonia bilateral</u>					<u>5 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Generalized arteriosclerosis - multiple infarcts</u>					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART II of item 18.) <u>584X</u>		
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 <u>Sept 3rd 57</u> to <u>Oct 9th 57</u> and last saw <u>her</u> alive on <u>Oct 8th 1957</u> Death occurred at <u>11A</u> <u>A</u> m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <u>Ernest Younger, M.D.</u>			22b. ADDRESS <u>3624 Russell</u>		22c. DATE SIGNED <u>10-11-57</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u>	23b. DATE <u>OCT. 12 1957</u>	23c. NAME OF CEMETERY OR CREMATORY <u>MT. OLIVE CEM.</u>		23d. LOCATION (City, town, or county) (State) <u>ST. LOUIS Mo</u>	
24. FUNERAL DIRECTOR ADDRESS <u>Thomas Kutis 2906 Leavis</u>		25. DATE RECD. BY LOCAL REG. <u>OCT 14 '57</u>		26. REGISTRAR'S SIGNATURE <u>Carl Smith MD</u>	

(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

Samuel C. Dill

Licensed Embalmer No. 4347

P. O. Address 2906 Howard

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.