

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

STATE FILE NUMBER **40935**

1. Health,
& Welfare
5. Public
Health Service

S. 300
v. 1-56

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

FILED NOV 25 1957

Registration District No. **169** Primary Registration District No. **4263** Registrar's No. **64**

1. PLACE OF DEATH a. COUNTY KNOX			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURI b. COUNTY KNOX		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN NOVELTY		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN NOVELTY		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION NOVELTY		Length of stay in 1b	d. STREET ADDRESS None (If outside, give location)		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First BERTHA Middle E. Last BENSTINE			4. DATE OF DEATH Month NOV Day 9 Year 1957		
5. SEX FEMALE	6. COLOR OR RACE CAUCASIAN	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MARCH 18-1887	9. AGE (In years last birthday) 70	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY None	11. BIRTHPLACE (City and state or country) KNOX COUNTY		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME JAMES H. DUDGEON			14. MOTHER'S MAIDEN NAME MARY KATHERINE Mc CLOTHLIN		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) 0		16. SOCIAL SECURITY NO. 0	17. INFORMANT Address MRS. HOWARD WAGENER		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocarditis Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) Pneumonia DUE TO (c) Arteriosclerosis					INTERVAL BETWEEN ONSET AND DEATH Nov 2 1957 6 Nov 9 1957
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 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.) 4221		
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		STATE
21. I attended the deceased from Nov 2 1957 to Nov 9 1957 and last saw him her alive on Nov 9 1957 . Death occurred at _____ m on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE E. O. Holmes D.D. (Degree or title)		22b. ADDRESS Novelty, Mo		22c. DATE SIGNED Nov 21 1957	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE Nov. 11, 1957	23c. NAME OF CEMETERY OR CREMATORY I. O. O. F.		23d. LOCATION (City, town, or county) (State) BRASHEAR Mo.	
24. FUNERAL DIRECTOR ADDRESS Kelley Royce Brashear, Mo		25. DATE RECD. BY LOCAL REG. Nov 22-57	26. REGISTRAR'S SIGNATURE Kelle S. Hunolt.		

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 *Richard B. Kelly*
Licensed Embalmer No. *449*
P. O. Address *Edinboro, Pa.*

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.