

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-023113
STATE FILE NUMBER
8919

FILED JUN 27 1958		Registration District No. 318	Primary Registration District No. 1003	Registration No. 8919
1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN St. Louis	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION D.O.A. Homer Phillips Hospital		Length of stay in 1b	d. STREET ADDRESS 2825 A. Easton Ave.	(If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last Foster Bennett		4. DATE OF DEATH Month Day Year June 5, 1958.		
5. SEX Male <u>2</u>	6. COLOR OR RACE Col.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct, 20, 1904	9. AGE (In years last birthday) 53
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) Hickman Ky.	12. CITIZEN OF WHAT COUNTRY? USA.
13. FATHER'S NAME John Bennett		14. MOTHER'S MAIDEN NAME Annie ?		
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. None	17. INFORMANT Address Cecil Bennett 2720 Delmar Blvd.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Subarachnoid Hemorrhage (traumatic)</i>				INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.				
DUE TO (b)				
DUE TO (c)				E900.0 21
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 checked="" 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.) <i>Suffered in fall on steps in house.</i>			
20c. TIME OF INJURY Hour a. m. Month, Day, Year p. m. <i>6.5.58</i>	20d. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg. etc.) <i>House</i>			20e. CITY, TOWN, OR LOCATION <i>St Louis Mo</i>
20f. CITY, TOWN, OR LOCATION <i>St Louis Mo</i>	20g. COUNTY <i>Mo</i>			STATE
21. I attended the deceased from _____ to _____ and last saw her/him alive on _____ Death occurred at <i>500 p.m.</i> on the date stated above; and to the best of my knowledge, from the causes stated.				
22a. SIGNATURE <i>[Signature]</i>		22b. ADDRESS <i>1306 Clark</i>		22c. DATE SIGNED <i>6/9/58</i>
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE <i>6/11/58</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Greenwood Cemetery</i>	23d. LOCATION (City, town, or county) (State) <i>St. Louis Co. Mo.</i>	
24. FUNERAL DIRECTOR <i>Wright Funeral Home</i>		ADDRESS <i>3100 Easton Ave.</i>	25. DATE RECD. BY LOCAL REG. <i>JUN 9 '58</i>	26. REGISTRAR'S SIGNATURE <i>J. Earl Smith, M.D.</i>

(Licensed Embalmer's Statement on Reverse Side)

300
1-56

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All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes. 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

MEDICAL CERTIFICATION

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 *Arthur L. Hilliard*

Licensed Embalmer No. *42*

P. O. Address *3100 E*

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.