

Dr. Health,
& Welfare
S. Public
th Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-023114

STATE FILE NUMBER

318

1003

Registrar's No. 5567

42044
FILED JUN 16 1958

Registration District No. Primary Registration District No.

S. 300
v. 1-57

1. PLACE OF DEATH a. COUNTY			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY St. Louis		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <i>St. Louis, Mo.</i>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <i>Ellisville</i>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <i>Missouri Baptist Hosp.</i>		Length of stay in 1b	d. STREET ADDRESS (If outside, give location) <i>Rt. 1 Wois Ave.</i>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <i>Dennis Jerome Benson</i>			4. DATE OF DEATH Month Day Year <i>May 21 58</i>		
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>May 14, 1958</i>	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months Day Hours Min. <i>7</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Infant</i>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <i>St. Louis, Missouri</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>
13a. FATHER'S NAME <i>Raymond Leroy Benson</i>		13b. MOTHER'S MAIDEN NAME <i>Martha Lou Nelson</i>		14. NAME OF HUSBAND OR WIFE	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT Name Address <i>Martha Benson Ellisville, Missouri</i>		
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>Respiratory failure</i> <i>intracranial hemorrhage</i>					INTERVAL BETWEEN ONSET AND DEATH <i>1 week</i> <i>unknown</i>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <i>intracranial hemorrhage</i> DUE TO (c)					
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 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>760.0</i>			
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 <i>5-14-58</i> to <i>5-21-58</i> and last saw her alive on <i>5-20-58</i> Death occurred at <i>8 AM 8 A.M.</i> m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <i>Robt. L. Korn</i> (Degree or title) <i>M.D.</i>			22b. ADDRESS <i>8230 Forsythe Clayton Mo</i>		22c. DATE SIGNED <i>5-22-58</i>
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>5-31-58</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Anatomical Board</i>		23d. LOCATION (City, town, or county) (State) <i>St. Louis, Mo.</i>	
24. FUNERAL DIRECTOR <i>Rowland Mortuary</i>		ADDRESS <i>1104-06 Manchester</i>		25. DATE RECD. BY LOCAL REG. <i>MAY 28 '58</i>	26. REGISTRAR'S SIGNATURE <i>Carl Smith MD</i> <i>m & g</i>

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION

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.

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

Licensed Embalmer No.....

P. O. Address.....

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.