

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-004960
STATE FILE NUMBER

FILED FEB 24 1959

Registration District No.

93

Primary Registration District No.

Registrar's No.

59-11

300
-57

1. PLACE OF DEATH a. COUNTY Dade		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo b. COUNTY Dade	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Greenfield Mo		c. CITY OR TOWN Greenfield Mo	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 405 Wells St		d. STREET ADDRESS (If outside, give location) 405 Wells St	
3. NAME OF DECEASED (Type or print) First Lottie Middle Bennett Last Bennett		4. DATE OF DEATH Month Feb Day 3 Year 1959	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED ☒ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐	8. DATE OF BIRTH Aug 18 1884
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk		10b. KIND OF BUSINESS OR INDUSTRY Grocery	11. BIRTHPLACE (City and state or country) Greenfield Mo
13a. FATHER'S NAME Charles A Bennett		13b. MOTHER'S MAIDEN NAME Delia Gardner	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) no		16. SOCIAL SECURITY NO. 495-07-5743	17. INFORMANT Address Etta Bennett Greenfield 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) Cancer of pelvis Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 199?			INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour _____ Month, Day, Year _____ a.m. _____ p.m.			
20d. INJURY OCCURRED WHILE AT ☐ NOT WHILE WORK ☐ AT WORK ☐	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 2-1-58 to 2-3-59 and last saw her alive on Dec 1-58 Death occurred at 4:00 a.m. on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE Sholomon M.D. Greenfield Mo. (Degree or title)		22b. ADDRESS	22c. DATE SIGNED 2-15-59
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE Feb 5 1959	23c. NAME OF CEMETERY OR CREMATORY Greenfield	23d. LOCATION (City, town, or county) (State) Greenfield Mo.
24. FUNERAL DIRECTOR W.A. Allison ADDRESS Greenfield Mo.		25. DATE RECD. BY LOCAL REG. 2-17-1959	26. REGISTRAR'S SIGNATURE J. C. Canada

(Licensed Embolmer's Statement on Reverse Side)

W.O. Cowan, M.D. USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION
All diseases in Part I must be causally related.

MAR 19 1958

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 *W.R. Allison*

Licensed Embalmer No. *4404*

P. O. Address *Chicago, Ill.*

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.