

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-006894

STATE FILE NUMBER
2-1274

FILED FEB 26 1959

Registration District No. _____ Primary Registration District No. _____ Registrar's No. _____

300
-57

25
45
500

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Jefferson	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN Festus, Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. John's		Length of stay in lb 10 days	d. STREET ADDRESS (If outside, give location) Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First JACK Middle C. Last BENSON	4. DATE OF DEATH Month Feb. 5, 1959 Day Year
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5. SEX Male <input checked="" type="checkbox"/>	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 18, 1897	9. AGE (In years last birthday) 61	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) District Sales Mgr.	10b. KIND OF BUSINESS OR INDUSTRY Farm Supplies	11. BIRTHPLACE (City and state or country) Chicago, Ill	12. CITIZEN OF WHAT COUNTRY? U. S. A.
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13a. FATHER'S NAME Poma Benson	13b. MOTHER'S MAIDEN NAME Bessie Adler	14. NAME OF HUSBAND OR WIFE Icy Benson (NeeWarren)
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) Yes N.W.1	16. SOCIAL SECURITY NO.	17. INFORMANT Address Mrs. Icy Benson, R. # 3, Festus, Mo.
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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>Cerebral artery blockage</i> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <i>Chronic anemia assoc. w/ splenectomy</i> DUE TO (c) <i>pyloric stenosis + cystitis also enlarged prostate</i>		INTERVAL BETWEEN ONSET AND DEATH <i>2 1/2 hrs</i> <i>6 months</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <i>anemia - splenectomy</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" 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 I or PART II of item 18.) <i>600.0</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
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21. I attended the deceased from *1-24-59* to *2-5-59* and last saw her alive on *2-4-59 10 am*
Death occurred at *3:45 am* on *2-5-59* m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <i>Cohen M. D.</i>	22b. ADDRESS <i>3780 Washington Pk</i>	22c. DATE SIGNED <i>2-5-59</i>
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23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 2-7-59	23c. NAME OF CEMETERY OR CREMATORY Spring Hill Cem.	23d. LOCATION (City, town, or county) (State) Nashville, Tenn.
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24. FUNERAL DIRECTOR Vinyard Funeral Home, Inc. Festus, Mo.	25. DATE RECD. BY LOCAL REG. FEB 5 '59	26. REGISTRAR'S SIGNATURE <i>Loan Smith. M.D.</i>
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All diseases in Part I must be causally related.

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

Keith B. Vincent

Licensed Embalmer No. *4976*

P. O. Address *Festus, Mo.*

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.