

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-018937

STATE FILE NUMBER
Registrar's No. **4556**

FILED MAY 22 1959

Registration District No. _____ Primary Registration District No. _____

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		c. CITY OR TOWN St. Louis	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Lutheran Hospital		d. STREET ADDRESS (If outside, give location) 8721 Halls Ferry	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
Length of stay in 1b 75yrs		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First ANNA Middle Last BENNE			4. DATE OF DEATH Month May Day 8 Year 1959		
---	--	--	--	--	--

5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 18, 1883	9. AGE (In years last birthday) 75	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS Hours Min.
-------------------------	----------------------------------	---	--	---	--------------------------------	-------------------------------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At home	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) St. Louis, Missouri	12. CITIZEN OF WHAT COUNTRY? USA
---	-----------------------------------	--	--

13a. FATHER'S NAME Fred Luecke	13b. MOTHER'S MAIDEN NAME Louisa Meyer	14. NAME OF HUSBAND OR WIFE William H. Benne
--	--	--

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or years of service) NO	16. SOCIAL SECURITY NO. NONE	17. INFORMANT Mr. William A. Benne	Address 301 Argent
--	--	--	------------------------------

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Mediastinitis		INTERVAL BETWEEN ONSET AND DEATH 4 days
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) Rupture of esophagus (spontaneous)	4 days
	DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 5391		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.)
---	--

20c. TIME OF INJURY Hour a.m. p.m.	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE 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 May 4 '59 to May 8 '59 and last saw her/him alive on May 8 '59 Death occurred at 7:15p m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE Ramusbaum M.D. (Degree or title)	22b. ADDRESS 3701 Grandel St.	22c. DATE SIGNED 5-9-59
---	---	-----------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE May 12, 1959	23c. NAME OF CEMETERY OR CREMATORY Salem Ev. Lutheran Cemetery	23d. LOCATION (City, town, or county) (State) St. Louis County, Missouri
---	----------------------------------	--	--

24. FUNERAL DIRECTOR BEIDERWIEDEN F.H. INC., 1936 ST. LOUIS AVE	25. DATE RECD. BY LOCAL REG. MAY 11 '59	26. REGISTRAR'S SIGNATURE Mr. Loan Smith, M.D.
---	---	--

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

ALL DISUSES IN PART I MUST BE CAUSALLY RELATED.

Je-3-4430

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. 4570
P. O. Address St Louis

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.