

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-024479

FILED VS. JUL 31 1959 7/

STATE FILE NUMBER

Registration District No. _____ Primary Registration District No. 3012 Registrar's No. 68

1. PLACE OF DEATH a. COUNTY <u>Clay</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Clay</u>									
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Excelsior Springs</u>		Length of stay in lb <u>15 yrs</u>		c. CITY OR TOWN <u>Excelsior Springs</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>							
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>415 E. Broadway</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>415 E. Broadway</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) First <u>Martha</u> Middle <u>Mae</u> Last <u>Bennett</u>				4. DATE OF DEATH Month <u>July</u> Day <u>16</u> Year <u>1959</u>									
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <u>2-24-1887</u>		9. AGE (last birthday) <u>72</u>		IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____		IF UNDER 24 HR Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>At home</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (City and state or country) <u>Harrison County, Mo.</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>					
13a. FATHER'S NAME <u>Lafayette Williams</u>				13b. MOTHER'S MAIDEN NAME <u>Delcena Reece</u>				14. NAME OF HUSBAND OR WIFE <u>R. L. Bennett</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>yes, unknown</u>		17. INFORMANT Address <u>Marybelle Bennett, Ex. Springs, Mo.</u>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:										INTERVAL BETWEEN ONSET AND DEATH			
IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage</u>										<u>instant</u>			
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.										<u>sev. yrs.</u>			
DUE TO (b) <u>hypertension</u>										<u>sev. yrs.</u>			
DUE TO (c) <u>arteriosclerosis</u>										<u>sev. yrs.</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>3/8/59 fracture of tibia and fibula rt. leg</u>								PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" 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. Month, Day, Year _____		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 <u>Feb. 26, 1952</u> to <u>July 16, 1959</u> and last saw her <u>live</u> on <u>July 15, 1959</u> Death occurred at <u>3:30 A.M.</u> on the date stated above, and to the best of my knowledge, from the causes stated.													
22a. SIGNATURE <u>[Signature]</u> (Degree or title) <u>M. D.</u>						22b. ADDRESS <u>Excelsior Springs, Mo.</u>			22c. DATE SIGNED <u>7/25/59</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>7-18-59</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Masonic Cemetery</u>			23d. LOCATION (City, town, or county) (State) <u>Excelsior Springs, Mo.</u>						
24. FUNERAL DIRECTOR <u>Prichard Funeral Home, Inc.</u> <u>Excelsior Springs, Missouri</u>				25. DATE RECD. BY LOCAL REG. <u>7-26-59</u>		26. REGISTRAR'S SIGNATURE <u>Caroline Hutchings</u>							

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF



STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by

or by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____

Signature of Student Embalmer

Signed Lindell Jarman

Licensed Embalmer No. 4589

P. O. Address Evadine Springs

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to do 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.