

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS SEP 14 1959

59-028817

Registration District No. 133 Primary Registration District No. \_\_\_\_\_ Registrar's No. 110 STATE FILE NUMBER

1. PLACE OF DEATH				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)			
a. COUNTY <u>Harrison</u>		b. CITY (If outside Corporate limits, give TOWNSHIP only) OR TOWN <u>Lincoln Township</u>		Length of stay in 1b <u>Life</u>		a. STATE <u>Missouri</u> COUNTY <u>Harrison</u>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		c. CITY OR TOWN <u>Lincoln Township</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
d. STREET ADDRESS		(If outside, give location)		d. STREET ADDRESS		(If outside, give location)	
Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm		Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED				4. DATE OF DEATH			
First <u>Ruth</u>		Middle <u>Ellen</u>		Last <u>Benson</u>		Month <u>September</u> Day <u>8</u> Year <u>1959</u>	
(Type or print)							
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <u>11-15-94</u>	
9. AGE (last birthday) <u>64</u>		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 24 HR Hours _____ Min. _____			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housekeeper</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (City and state or country) <u>Illinois</u>		12. CITIZEN OF WHAT COUNTRY <u>U. S.</u>	
13a. FATHER'S NAME <u>Addison Ray Hobbs</u>		13b. MOTHER'S MAIDEN NAME <u>Alice Thromperton</u>		14. NAME OF HUSBAND OR WIFE <u>John Benson</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>498-42-3737</u>		17. INFORMANT <u>John Benson - Hatfield, Missouri</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		IMMEDIATE CAUSE (a) <u>Auricular Fibrillation with Cerebral Embolus</u>				INTERVAL BETWEEN ONSET AND DEATH <u>24hrs</u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		DUE TO (b) <u>Arteriosclerotic Cardiovascular Disease</u>				DUE TO (c) <u>5yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)				PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input 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>1950</u> to <u>Sept 8, 59</u> and last saw her <u>Sept 7</u> alive on		Death occurred at <u>5am</u> on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <u>Frank B Matteson M D</u>		22b. ADDRESS <u>Grant City Mo</u>		22c. DATE SIGNED <u>9/9/59</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>9-10-1959</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Lotts Groove Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Worth County, Missouri</u>	
24. FUNERAL DIRECTOR <u>Bell A. Dunfee - Grant City</u>		ADDRESS		25. DATE RECD. BY LOCAL REG. <u>9-10-1959</u>		26. REGISTRAR'S SIGNATURE <u>Gella Mayey</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 Bill A. Duff

Licensed Embalmer No. 4902

P. O. Address Frank

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.