

FRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-032220

FILED OCT 13 1959

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 4482 STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY Jackson				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Jackson				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kansas City		Length of stay in 1b 5 days		c. CITY OR TOWN Independence		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION V. A. Hospital			Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) 19006 E. 9th.		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Chris Middle Bennett Last Bennett				4. DATE OF DEATH Month September Day 13, Year 1959				
5. SEX male	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 3-26-1893	9. AGE (last birthday) 66	IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/>	IF UNDER 24 HR Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Grinder			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) Pawnee, Nebraska		12. CITIZEN OF WHAT COUNTRY U. S. A.	
13a. FATHER'S NAME Clay Bennett			13b. MOTHER'S MAIDEN NAME Eliza Unknown			14. NAME OF HUSBAND OR WIFE Fern Bennett		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) yes 9-21-17 to 2-22-18			16. SOCIAL SECURITY NO. 500-22-6079		17. INFORMANT Address Official Records VA Hosp. K. C. 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) encephlomalacia, right cerebellar hemisphere DUE TO (b) thrombosis of right veterbral artery DUE TO (c) arteriosclerosis Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH	
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 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 <input type="checkbox"/> a.m. <input type="checkbox"/> 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 9-8-59 to 9-13-59 Death occurred at 11:10P. m on the date stated above, and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE (Degree or title) ALBERT L. CHASSON, M.D.				22b. ADDRESS V. A. Hospital, Kansas City, Mo.		22c. DATE SIGNED 9-14-59		
23a. BURIAL, CREMATION, REMOVAL (Specify) removal		23b. DATE 9-16-59	23c. NAME OF CEMETERY OR CREMATORY Oak Ridge Memo. Gardens		23d. LOCATION (City, town, or county) (State) Independence, Mo.			
24. FUNERAL DIRECTOR ADDRESS D. W. Newcamer's Sons K. C. Mo.			25. DATE RECD. BY LOCAL REG. 9-15-59		26. REGISTRAR'S SIGNATURE Neva Marshall			

DOCUMENT

BY AFFIDAVIT OF **Albert L. Chasson** 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
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed _____

Licensed Embalmer No. _____

P. O. Address _____

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