

FEDERAL DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-035484

FILED VS SEP 28 1960

Registration District No. 209 Primary Registration District No. 3043 Registrar's No. 376

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>Marion</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Audrain</u>											
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Hannibal</u>		Length of stay in 1b <u>2 days</u>		c. CITY OR TOWN <u>Vandalia</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>St. Elizabeth</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>605 Pershing</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>								
3. NAME OF DECEASED (Type or print) First <u>Ora</u> Middle <u>Toad</u> Last <u>Benn</u>				4. DATE OF DEATH Month <u>September</u> Day <u>13</u> Year <u>1960</u>											
5. SEX <u>Male</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>3-22-88</u>		9. AGE (last birthday) <u>72</u>		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		IF UNDER 24 HR Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <u>Ralls Co.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>							
13a. FATHER'S NAME <u>Marion Benn</u>				13b. MOTHER'S MAIDEN NAME <u>Jamina Inlow</u>				14. NAME OF HUSBAND OR WIFE <u>Mabell Benn</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>488-24-5101</u>		17. INFORMANT Address <u>Mabell Benn, Vandalia, Mo.</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>Posterior coronary occlusion</u> <u>Myocardial infarction</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u> </u> DUE TO (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I. <u>none</u>										INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>years</u>					
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 <u> </u> Month, Day, Year <u> </u>		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 <u> </u> COUNTY <u> </u> STATE <u> </u>	
21. I attended the deceased from <u>Jan 30, 1950</u> to <u>September 13, 1960</u> and last saw him alive on <u>9/13/60</u> Death occurred at <u>1053 AMDST</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>MD</u>						22b. ADDRESS <u>Vandalia Mo</u>				22c. DATE SIGNED <u>9/16/60</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>9-15-60</u>		23c. NAME OF CEMETERY OR CREMATOR <u>Vandalia Cemetery</u>				23d. LOCATION (City, town, or county) <u>Vandalia, Missouri</u> (State)							
24. FUNERAL DIRECTOR <u>William Shaters, Vandalia, Mo</u> ADDRESS				25. DATE RECD. BY LOCAL REG. <u>9/19/60</u>		26. REGISTRAR'S SIGNATURE <u>Dr. E. M. Lusk by Lillian M. Kerman</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 William Blanton

Licensed Embalmer No. 4169

P. O. Address Vandalia, Mo.

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.