

**MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH**

Do not use this space.

10995

**1. PLACE OF DEATH**

County.....

Registration District No. 701

File No. ....

Township.....

Primary Registration District No. **ISOLATION HOSPITAL**

Registered No. 2932

City St. Louis (No. ....)

St. 24th Ward)

**2. FULL NAME**

Margaret Benshaw

(a) Residence. No. 1301 a S. 8th St., 22 Ward.

(If nonresident, give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)

Female White Married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

John F. Benshaw

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Nov. 10, 1907

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, ..... hrs. or ..... min.  
22 4 11

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. House wife

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9. BIRTHPLACE (CITY OR TOWN)

(STATE OR COUNTRY) Canada

10. NAME OF FATHER

Joseph Walsh

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY) Canada

12. MAIDEN NAME OF MOTHER

Mary Roberts

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY) Canada

14.

INFORMANT (Address)

S. Krouner  
**ISOLATION HOSPITAL**

15.

FILED

MAR 23 1930  
May C. Stankley  
REGISTRAR

2.

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) 3-21 1930

17. I HEREBY CERTIFY, That I attended deceased from 3-17, 1930, to 3-21, 1930 that I last saw her alive on 3-21, 1930 and that death occurred, on the date stated above, at 6:00 P. m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

Typhoid Fever

107A

(duration) ..... yrs. .... mos. 14 ds.

CONTRIBUTORY (SECONDARY)

Pseudo pneumonia

(duration) ..... yrs. .... mos. 3 ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH.....

DID AN OPERATION PRECEDE DEATH?..... DATE OF.....

WAS THERE AN AUTOPSY?.....

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed)

R. H. Bell

3-22, 1930 (Address) **ISOLATION HOSPITAL**

\*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) Whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL

DATE OF BURIAL

Calvary Cemetery

3/24 1930

20. UNDERTAKER

ADDRESS

McLaughlin 1651 mo. ave.

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

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