

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

Do not use this space.

13500

MAY 27 1930

1. PLACE OF DEATH

County Osage
Township Benton
City St. Aubert (No. _____)

Registration District No. _____
Primary Registration District No. 1711

File No. _____
Registered No. _____
St. _____ Ward _____

2. FULL NAME

Ruby May Benedict
(a) Residence No. _____ St. _____ Ward _____
(Usual place of abode)
Length of residence in city or town where death occurred yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Single

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF None

6. DATE OF BIRTH (MONTH, DAY AND YEAR) April 19/1929

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
11 20

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer) None
(c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) St. Aubert Mo
(STATE OR COUNTRY) Osage Co

PARENTS
10. NAME OF FATHER James T. Benedict
11. BIRTHPLACE OF FATHER (CITY OR TOWN) St. Aubert
(STATE OR COUNTRY) Osage Co Mo
12. MAIDEN NAME OF MOTHER Leola F. King
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Isabel Dale
(STATE OR COUNTRY) Osage Co Mo

14. INFORMANT Harrison Benedict
(Address) St. Aubert Mo

15. FILED 5/2 30 1930 Esther Sorder
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) April 9th 1930

17. I HEREBY CERTIFY, That I attended deceased from March 1st, 1930, to April 9th, 1930, that I last saw her alive on April 9th, 1930, and that death occurred, on the date stated above, at 12:45 P. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Benedict's pneumonia
10°C
97A
(duration) yrs. mos. da.
CONTRIBUTORY (SECONDARY) _____
(duration) yrs. mos. da.

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) W. H. Courley, M. D.
, 19 (Address) Chamois Mo

*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 ST AUBERT, MO. DATE OF BURIAL 4/10/1930

20. UNDERTAKER F. A. ENGELAGE, CHAMOIS, MO.
ADDRESS _____

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

V. S. NO. 2. R. 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.

