

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. PHYSICIANS should be stated EXACTLY. AGE should be stated EXACTLY.

2660 AUG 18 1939

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

26190
 Do not use this space.

1. PLACE OF DEATH
 (a) County Macon Registration District No. 533
 (b) Township Hudson Primary Registration District No. 5713
 (c) City _____ (d) Street No. _____ St. _____
 (e) Length of residence in city or town where death occurred _____ mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME John M. Bennett
 (a) Residence, No. _____ St. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX Male 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Widower
 6A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) OK
 7. AGE YEARS 78 MONTHS _____ DAYS _____ If LESS than 1 day, _____ hrs. or _____ min.
 OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Retired
 9. Industry or business in which work was done, as saw mill, bank, etc. _____
 10. Date deceased last worked at this occupation (month and year) _____ 11. Total time (years) spent in this occupation _____
 12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) OK County, Mo.
 FATHER 13. NAME Record
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) OK No. 9
 MOTHER 15. MAIDEN NAME OK
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) _____
 17. INFORMANT (ADDRESS) Mrs. Vera Pacey, Sept County, Macon Mo.
 18. BURIAL, CREMATION, OR REMOVAL PLACE Woodlawn Burial DATE 7-11-1939
 19. FUNERAL DIRECTOR (NAME) (ADDRESS) Stephens Gooding, Macon Mo.
 20. FILED 8/5 1939 Leola Hunter Local Registrar.

21. DATE OF DEATH (MONTH, DAY, AND YEAR) July 10 1939
 22. I HEREBY CERTIFY That I attended deceased from _____ 1939, to July 10 1939
 I last saw h. Anna alive on July 10 1939, Death is said to have occurred on the date stated above, at 5:30 p.m.
 The principal cause of death and related causes of importance were as follows:
General Paralysis Date of onset 1935
 Other contributory causes of importance:
Multiple Arthritis 1930
Systemic Arthritis 1915
 Name of operation _____ Date of _____
 What test confirmed diagnosis? Chemical Was there an autopsy? _____
 23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide? _____ Date of injury _____, 19____
 Where did injury occur? _____ (Specify city or town, county, and State)
 Specify whether injury occurred in industry, in home, or in public place. _____
 Manner of injury _____
 Nature of injury _____
 24. Was disease or injury in any way related to occupation of deceased? no
 If so, specify _____ (Signed) J. J. Turner, M. D.
 (Address) Macon, Mo.

57a

RECEIVED

District Health Officer No. 10

District File Number 8-39-1422

Date Filed AUG 9 1939

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,

Not Embalmed

or by

Registered Apprentice No.

working under my personal supervision.

Signed

C. S. Stephens

Licensed Embalmer No.

P. O. Address

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 this body is not embalmed, above space should be left blank.

FILL IN ANSWERS TO ALL SPACES
CHECKED IN RED PENCIL.

MISSOURI STATE BOARD OF HEALTH
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CERTIFICATE OF DEATH

26190
Do not use this space.

1. PLACE OF DEATH

(a) County Macon Registration District No. 533
(b) Township Hudson Primary Registration District No. 5713 Registered No. _____
(c) City _____ (d) Street No. _____ St. _____
(If death occurred in Hospital or Institution, write its name instead of street and number)
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U.S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

(a) Residence, No. John M. Bennett St. (If nonresident, give city or town and State)
(Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX m 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) wid

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

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

7. AGE YEARS 78 MONTHS _____ DAYS _____ If LESS than 1 day, _____ hrs. or _____ min.

OCCUPATION
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.
9. Industry or business in which work was done, as saw mill, bank, etc.
10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

FATHER
13. NAME

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

MOTHER
15. MAIDEN NAME

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL

PLACE _____ DATE _____, 19____

19. FUNERAL DIRECTOR (ADDRESS)

20. FILED _____, 19____

Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 7-10-1939

22. I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____

I last saw h. _____ alive on _____, 19____. Death is said to have occurred on the date stated above, at _____ m.

The principal cause of death and related causes of importance were as follows:

General Paralysis
93
Date of onset _____

Other contributory causes of importance:

Multiple Arteriosclerosis
Systemic Arteriosclerosis

Name of operation _____ Date of _____

What test confirmed diagnosis? _____ Was there an autopsy? _____

23. If death was due to external causes (violence), fill in also the following: Accident, suicide, or homicide? _____ Date of injury _____, 19____

Where did injury occur? _____ (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury _____

Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? _____

If so, specify _____ (Signed) G. G. Barnes, M. D.

(Address) Macon

SUPPLEMENTARY

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW. No property assessed. Exact statement of OCCUPATION is very important.

1939
S-26190