

SEP 6 1939

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

28139
Do not use this space.

1. PLACE OF DEATH

(a) County Jackson Registration District No. 399
 (b) Township Ray Primary Registration District No. 1007
 (c) City H. C. (d) Street No. St. Lukes Hosp Registered No. 3141
 (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. 4410 East 56th St 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 Fe 4. COLOR OR RACE wh 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) married
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Howard F. Benedict
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Sept 3rd 1899
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min. 39 11 5
 OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Housewife
 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) Mo
 FATHER 13. NAME Thos R Hartness
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ind
 MOTHER 15. MAIDEN NAME Cora Handley
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Mo
 17. INFORMANT (ADDRESS) Mrs Mable Eddy 4927 Park Ave
 18. BURIAL, CREMATION, OR REMOVAL PLACE DATE High Hill Cem 8/10/39
 19. FUNERAL DIRECTOR (NAME) (ADDRESS) H. F. Meyers, H. C. Mo
 20. FILED 8 1939 M. M. Brown Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 8/8/39, 1939
 22. I HEREBY CERTIFY, That I attended deceased from Aug 1 1939 to Aug 7 1939
 I last saw the decd. alive on Aug 7 1939 Death is said to have occurred on the date stated above, at 4:30 a.m.
 The principal cause of death and related causes of importance were as follows:
Mitral stenosis years
920
 Other contributory causes of importance:
Cardiac failure following operation
 Name of operation Laprotomy repair Date of Aug 7
 What test confirmed diagnosis? no Was there an autopsy? no
 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 Theodore H. Aschmann, M. D.
 (Address) 1518 Prof Bldg K.C. Mo.

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.

George W. Bell
Mar. 14, 1911

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,

....., or by

Registered Apprentice No....., working under my personal supervision.

Signed.....

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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

State File No. 28139

Registration District No.

Primary Registration District No.

Registrar's No. 3141

1. PLACE OF DEATH:

(a) County Jackson R.L.
 (b) City or town R.L.
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution.....
 In this community..... (Specify whether
 years, months or days)

3. (a) PRINT FULL NAME Frances Benedict

3. (b) If veteran, name war..... 3. (c) Social Security No.....

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced M

6. (b) Name of husband or wife..... 6. (c) Age of husband, or wife, if alive..... year.....

7. Birth date of deceased. (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
39 11 5 hr. min.

9. Birthplace..... (City, town, or county) (State or foreign country)

10. Usual occupation.....

11. Industry or business.....

12. Name.....

13. Birthplace..... (City, town, or county) (State or foreign country)

14. Maiden name.....

15. Birthplace..... (City, town, or county) (State or foreign country)

16. (a) Informant.....

(b) Address.....

17. (a) (Burial, cremation, or removal) (b) Date thereof. (Month) (Day) (Year)

(c) Place: burial or cremation.....

18. (a) Signature of funeral director.....

(b) Address 8787 39

19. (a) (Date received local registrar) (b) M.M. Browe (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State..... (b) County.....
 (c) City or town..... (If outside city or town limits write "RURAL")
 (d) Street No..... (If rural, give location)
 (e) If foreign born, how long in U. S. A.?..... years.

MEDICAL CERTIFICATION

20. DATE OF DEATH Month Aug Day 24
 year..... hour..... minute..... M.

21. I hereby certify that I attended the deceased from....., 19....., to....., 19.....; that I last saw him..... alive on..... and that death occurred on the date and hour stated above.

Immediate cause of death
Myocardial infarction
 Due to Cardiac failure following operation
 Due to vaginal repair
 Other conditions..... (If child pregnancy within months of death)
Theodore H. Aschman
 Major findings: Laparotomy 8-4-34
 Of operations.....
 Of autopsy.....

Duration
 PHYSICIAN
 Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
 (a) Accident, suicide, or homicide (specify).....
 (b) Date of occurrence.....
 (c) Where did injury occur? (City or town) (County) (State)
 (d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work? (Specify type of place) (e) Means of injury

23. Signature..... (M. D. or other).....
 Address..... Date signed.....

SUPPLEMENTARY

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

