

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **34859**

Registration District No. _____

Primary Registration District No. _____

Registrar's No. **3834**

1. PLACE OF DEATH:

(a) County Jackson
(b) City or town Kansas City
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: W. C. Gun Hosp't 1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 23 days
(Specify whether
In this community 36 years
years, months or days)

REC'D NOV 14 1939

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County Jackson
(c) City or town Kansas City
(If outside city or town limits, write "RURAL")
(d) Street No. 2940 West
(If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION

3. (a) PRINT FULL NAME Claude C Benfer

20. DATE OF DEATH: Month Oct day 4
year 1939 hour 6 minut _____ A.M.

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

21. I hereby certify that I attended the deceased from Sept 11, 1939 to Oct 4, 1939, that I last saw him live on Oct 4 - 1939 and that death occurred on the date and hour stated above.

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

Immediate cause of death Myocardial infarction Duration _____
phage (int. capsule)
Septic cephalo-clasis

6. (b) Name of husband or wife Anna C Benfer 6. (c) Age of husband or wife if alive 69 years
7. Birth date of deceased Sept 27, 1868
(Month) (Day) (Year)

Due to Chronic Intestinal Myocardial infarction

8. AGE: Years 71 Months 0 Days 7 If less than one day _____ hr. _____ min.

Due to Generalized arteriosclerosis

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

Other conditions _____
(Include pregnancy within 3 months of death)

10. Usual occupation Chamber

Major findings: Of operations _____
Of autopsy See above

11. Industry or business _____

12. Name John Benfer

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

14. Maiden name Elizabeth

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

16. (a) Informant's own signature Reard Clerk

(b) Address W. C. Gun Hosp't

17. (a) Removal (b) Date thereof 10-5-39
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Shivatha, Kansas

18. (a) Signature of funeral director Freeman Martiny

(b) Address Kansas City, Mo.

19. (a) 10-4-39 (b) M. M. Crowe, M.D.
(Date received local registrar) (Registrar's signature)

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)
(a) Means of injury _____

23. Signature PT De Maria MD (M. D. or other) _____
Address Sept W. C. Gun Hosp't Date signed _____

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

WHILE FILLING IN USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1 X1931

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.

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.