

9-4-41  
17-39  
X2942

NOV 18 1943

Registration District No. 170

Primary Registration District No. 5628

Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH:

(a) County Laclede

(b) City or town Bronfield  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Rural  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether \_\_\_\_\_)

In this community 63 years  
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Laclede <sup>33</sup>

(c) City or town Bronfield  
(If outside city or town limits, write "RURAL") <sup>0</sup>

(d) Street No. Rural  
(If rural, give location) <sup>0</sup>

(e) Citizen of foreign country? No (Yes or No)

If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME WILLIAM LAWRENCE BENCH

3. (b) If veteran, name war \_\_\_\_\_

3. (c) Social Security No. \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month October, day 5th  
year 1943 hour 6 minute 30 A.M.

4. Sex Male 5. Color or race white

6. (a) Single, widowed, married, divorced married

6. (b) Name of husband or wife Ellenore Bench

6. (c) Age of husband or wife if alive 66 years

7. Birth date of deceased: July 11 1880  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from March 1, 1943, to October 5th, 1943 that I last saw him alive on October 4th, 1943 and that death occurred on the date and hour stated above.

Immediate cause of death: Respiratory failure & shock Duration

8. AGE: Years Months Days If less than one day

63 2 13 6 hr. 30 min.

Due to Internal Hemorrhage

Due to Hypertension (Circulatory)

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

10. Usual occupation Farmer & Post Master

11. Industry or business Farming

12. Name William R. Bench

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

14. Maiden name Sarah C. Cook

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

16. (a) Informant Edolph Murphy Bench

(b) Address Bronfield, Mo

17. (a) Burial (b) Day thereof 10-10-43  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Riverview mg

18. (a) Signature of funeral director R. B. Zupser

(b) Address Riverview mg

19. (a) Oct 21-43 (b) Grace Roper  
(Date received local registrar) (Registrar's signature)

Other conditions (Include pregnancy within 3 months of death)

PHYSICIAN

Major findings: Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

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) (c) Means of injury 3

23. Signature R. B. Zupser (M. D. or other) D.D.

Address Lebanon mo Date signed 10-11-43

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

MOTHER FATHER

Received .....

Laclede County Health Unit

File No. 10-43-145

Date Filed 11-15-43

AUG 18 1944

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. 3198

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, fact should be so stated above.

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. Dec

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH:

(a) County Laclede

(b) City or town Rural  
(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 \_\_\_\_\_ (Specify whether \_\_\_\_\_)

In this community 63 yr.  
years, months or days)

3. (a) PRINT FULL NAME Wm. L. Bench

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

4. Sex m 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 66 years

7. Birth date of deceased July 11 1880  
(Month) (Day) (Year)

8. AGE: Years 63 Months 2 Days 15 If less than one day \_\_\_\_\_ min. 50

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

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

MOTHER FATHER { 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) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_ (Month) (Day) (Year)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_ (b) Address \_\_\_\_\_

19. (a) \_\_\_\_\_ (b) \_\_\_\_\_ (Date received local registrar) (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) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct Day \_\_\_\_\_ Year 1943 Hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_; \_\_\_\_\_, 19\_\_\_\_;

that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_; and that death occurred on the date and hour stated above. Immediate cause of death Respiratory failure and shock

Due to Internal Hemorrhage

Due to Hypertension Circulatory

Other conditions (include pregnancy within 3 months of death) \_\_\_\_\_

Major findings: Of operations \_\_\_\_\_

Of autopsy None performed

22. If death was due to external causes, fill in the following:  
(a) Accident, suicide, or homicide (specify) Death was not  
(b) Date of occurrence due to external causes  
(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) (c) Means of injury \_\_\_\_\_

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

SUPPLEMENTARY

INDIGENOUS

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

38526