

FILED OCT 23 1944

Registration District No. **818**

Primary Registration District No. **1003**

Registrar's No. **8886**

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

17
9

1. PLACE OF DEATH:

(a) County **St. Louis, Missouri**

(b) City or town **St. Louis, Missouri**
(If outside city or town limits, write "RURAL" and name of township)

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

(d) Length of stay: In hospital or institution **7 days** (Specify whether **0**)

In this community _____ years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State **Illinois** (b) County **McLean** **999**

(c) City or town **Bloomington** **11**
(If outside city or town limits, write "RURAL")

(d) Street No. **714 S. Clayton Street** **NR. 2**
(If rural, give location)

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

If yes, name country _____

3. (a) PRINT FULL NAME **BENNIE GIFFORD BLACK**

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

4. Sex **M** **0** 5. Color or race **Wh** 6. (a) Single, widowed, married, divorced **Married**

6. (b) Name of husband or wife **Harriet Black** 6. (c) Age of husband or wife if alive **43** years

7. Birth date of deceased **June 26 1896**
(Month) (Day) (Year)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **October** day **18**
year **1944** hour **11** minute **20 A.M.**

21. I hereby certify that I attended the deceased from **OCT. 11 1944**, to **OCT. 18 1944**
that I last saw h.t.m. alive on **OCT. 18 1944**
and that death occurred on the date and hour stated above.

8. AGE: Years **48** Months **3** Days **22** If less than one day
hr. _____ min. _____

Immediate cause of death **Hemorrhage**

Due to **Cancer of the lung**

Due to _____

Other conditions (Include pregnancy within 3 months of death) **H7**

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

10. Usual occupation **Mechanic**

11. Industry or business **Office Equipment**

12. Name **David Black**

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

14. Maiden name **Margaret Tarkington**

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

16. (a) Informant **Wife- Mrs. Harriet Black**
(b) Address **Bloomington, Ill.**

17. (a) **Removal** (b) Date thereof **10-19-44**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Bloomington, Ill.**

18. (a) Signature of funeral director **Albert H. Hoppe**
(b) Address **4700 Washington Blvd.**

19. (a) **9 1944** (b) **J. F. Budzich**
(Date received local registrar) (Registrar's signature)

Major findings: **Extensive carcinoma of right upper lobe.**

Of autopsy **as above**

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 **Wm. Greenhaw** (M. D. or other)
Address **Barnes Hospital** Date signed **10/18/44**

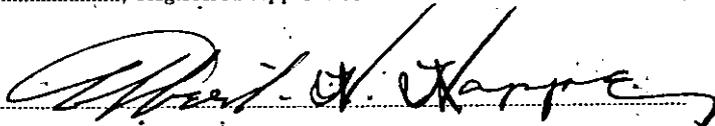
FEB 26 1957

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. 1861

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.