

No. 2  
-5-42  
-17-39  
X32873

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **2142**  
Registrar's No. **108**

**FILED JAN 20 1945**

Registration District No. \_\_\_\_\_ Primary Registration District No. **3020**

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

**1. PLACE OF DEATH:**  
 (a) County **Franklin**  
 (b) City or town **Washington**  
(If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution:  
**St. Francis Hospital**  
(If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution **2 days**  
(Specify whether  
 In this community \_\_\_\_\_  
years, months or days)

**2. USUAL RESIDENCE OF DECEASED:**  
 (a) State **Missouri** (b) County **Montgomery 70**  
 (c) City or town **Rural**  
(If outside city or town limits, write "RURAL")  
 (d) Street No. \_\_\_\_\_  
(If rural, give location)  
 (e) Citizen of foreign country? **no** (Yes or No)  
 If yes, name country \_\_\_\_\_

**3. (a) PRINT FULL NAME** **Martha Florence Benny**  
 3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

**MEDICAL CERTIFICATION**  
**20. DATE OF DEATH:** Month **December** day **9**  
 year **1944** hour **6:30** minute \_\_\_\_\_ P. A. M.

4. Sex **Female** 5. Color or race **white** 6. (a) Single, widowed, married, divorced, **widowed**  
 6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
 7. Birth date of deceased **September 8, 1876**  
(Month) (Day) (Year)

**21. I hereby certify that I attended the deceased from**  
**July 20, 1944, to December 9, 1944**  
 that I last saw her alive on **December 8, 1944**  
 and that death occurred on the date and hour stated above.

**8. AGE:** Years **68** Months **3** Days **1** If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

Immediate cause of death **Pneumonia** **Duration 1 week**  
 Due to **Gastric Carcinoma** **2 yrs**

**9. Birthplace:** **Arkansas**  
(City, town, or county) (State or foreign country)  
**10. Usual occupation** **at home**

Due to \_\_\_\_\_  
 Other conditions **Hepatic congestion** **3 weeks**  
(Include pregnancy within 3 months of death)

**11. Industry or business** \_\_\_\_\_  
**MOTHER FATHER** { **12. Name** **Jasper Reno**  
**13. Birthplace** **Cooper County Missouri**  
(City, town, or county) (State or foreign country)  
**14. Maiden name** **Emmaline Thornton**  
**15. Birthplace** **Cooper County Missouri**  
(City, town, or county) (State or foreign country)

**Major findings:** **ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED**  
 Of operations \_\_\_\_\_  
 Of autopsy \_\_\_\_\_  
**PHYSICIAN**  
 Underline the cause to which death should be charged statistically.

**16. (a) Informant** **Mrs. Albert Rattles**  
**(b) Address** **Warrenton, Mo.**

**22. If death was due to external causes, fill in the following:**

**17. (a) Burial** (b) Date thereof **12-11-44**  
(Burial, cremation, or removal) (Month) (Day) (Year)  
**(c) Place: burial or cremation** **Jonesburg, Mo.**  
**18. (a) Signature of funeral director** **J. M. Schuch & Co.**  
**(b) Address** **Warrenton, Mo.**  
**19. (a) 12-10-44** (b) **Lucille R. Brooks**  
(Date received local registrar) (Registrar's signature)

**(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?** \_\_\_\_\_  
(Specify type of place)  
 While at work? \_\_\_\_\_ (e) Means of injury \_\_\_\_\_  
**23. Signature** **Lepold Loehane** (M. D. or other) **M.D.**  
**Address** **Warrenton, Mo.** **Date signed** **12-9-44**

**1181** (Licensed Embalmer's Statement on Reverse Side)

4-45  
102

AUG 14 1945

RECEIVED  
District Health Officer No. 9,  
District File Number.....  
Date Filed 1-18-45

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, by.....

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

Signed John J. Hebing  
Licensed Embalmer No. 3897  
P. O. Address Waukegan, Ill.

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.

Registration District No. 116 Primary Registration District No. 3020

1. PLACE OF DEATH:  
(a) County Franklin  
(b) City or town Washington  
(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 \_\_\_\_\_ years, months or days

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 \_\_\_\_\_

3. (a) PRINT FULL NAME Martha F. Benny  
3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month Feb Day \_\_\_\_\_ Year 1944 Hour \_\_\_\_\_ Minute \_\_\_\_\_ M.  
21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_; that I last saw him/her alive on \_\_\_\_\_, 19\_\_\_\_; and that death occurred on the date and hour stated above. Immediate cause of death \_\_\_\_\_

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced W  
6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased: Sept (Month) 8 (Day) 1908 (Year)

Due to \_\_\_\_\_  
Due to Primary seat of cancer:  
Other conditions stomach  
(Include pregnancy within 3 months of death)

8. AGE: Years 68 Months 3 Days \_\_\_\_\_ (Unless than one day) min.  
9. Birthplace Ark (City, town, or county) (State or foreign country)

PHYSICIAN \_\_\_\_\_  
Major findings: Of operations \_\_\_\_\_  
Of autopsy Hob  
Underline the cause to which death should be charged statistically.

10. Usual occupation \_\_\_\_\_  
11. Industry or business \_\_\_\_\_  
MOTHER FATHER { 12. Name \_\_\_\_\_  
13. Birthplace \_\_\_\_\_ (City, town, or county) (State or foreign country)  
14. Maiden name \_\_\_\_\_ (State or foreign country)  
15. Birthplace \_\_\_\_\_ (City, town, or county) (State or foreign country)  
16. (a) Informant \_\_\_\_\_ (b) Address \_\_\_\_\_  
17. (a) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_ (Month) (Day) (Year)  
(Burial, cremation, or removal) (Specify whether \_\_\_\_\_)  
(c) Place: burial or cremation \_\_\_\_\_  
18. (a) Signature of funeral director \_\_\_\_\_ (b) Address \_\_\_\_\_  
19. (a) \_\_\_\_\_ (b) \_\_\_\_\_ (Registrar's signature)  
(Date received local registrar)

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 Edold Belance (M. D. or other) M.D.  
Address Warrenton, Mo Date signed 4-15-45

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

SUPPLEMENTARY

453-9-108

S-2142