#41071

S. No. 2
M—5-42
5-17-39
P I X32873

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 14934 43

FILED MAY 25 1945 318

Registration District No. ..... Primary Registration District No. 1003 Registrar's No. .....

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

1. PLACE OF DEATH:

(a) County .....

(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:
St. Louis City Hospital #1. 0
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 1mo-2 days (Specify whether years, months or days)

In this community .....

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jefferson

(c) City or town Festus
(If outside city or town limits, write "RURAL")

(d) Street No. 503 N. 2nd
(If rural, give location)

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

If yes, name country .....

N.R.

3. (a) PRINT FULL NAME Fern Bennett

3. (b) If veteran, name war —

3. (c) Social Security No. —

4. Sex Female

5. Color or race White

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

6. (b) Name of husband or wife Kenneth Bennett

6. (c) Age of husband or wife if alive 22 years

7. Birth date of deceased June (Month) 14 (Day) 1924 (Year)

8. AGE: Years 20 Months 11 Days 3 If less than one day ..... hr. ..... min.

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

10. Usual occupation .....

11. Industry or business .....

MOTHER FATHER

12. Name Charles Mercer

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

14. Maiden name Alice Countaway

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

16. (a) Informant Alice Mercer

(b) Address Festus mo

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-20-45 (Month) (Day) (Year)

(c) Place: burial or cremation Herculaneum, Mo

18. (a) Signature of funeral director Zink Und. Co.

(b) Address Festus mo

19. (a) MAY 17 1945 (Date received local registrar) (b) J. F. Bredeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 17th year 1945 hour 4:30 minute A. M.

21. I hereby certify that I attended the deceased from 4/15/45, 19..., to 5/17/45, 19...; that I last saw her alive on 5/17/45, 19...; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Emphysema c̄ P.O.B.	
Spontaneous broncho-pulmonary fistula	6 days
Due to RLL pneumonia, pleural	
Lobectomy	
Due to	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations Bronchoscopy RLL

Of autopsy none

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? ..... (Specify type of place)

While at work? ..... (e) Means of injury .....

23. Signature McKeva (M. D. or other)

Address 1515 Lafayette Date signed 5/17/45

(Licensed Embalmer's Statement on Reverse Side)

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 Elena Province

Licensed Embalmer No. 3403

P. O. Address Festus Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wi the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

S. No. 2B
5M—3-45
Form I X43880

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. June

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 4373

1. PLACE OF DEATH:

(a) County
(b) City or town St Louis
(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 years, months or days)
In this community

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 Fern Bennett
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 years
7. Birth date of deceased June 14 1924 (Month) (Day) (Year)
8. AGE: Years 20 Months 1 Days 3 If less than one day hr. min.
9. Birthplace (City, town, or county) Mo (State or foreign country)
10. Usual occupation Housework
11. Industry or business
12. FATHER Name
13. FATHER Birthplace (City, town, or county) (State or foreign country)
14. MOTHER Maiden name
15. MOTHER 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
19. (a) JUN 4 1945 (Date received local registrar) J. F. Bredeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May 7 year 1945 hour minute M.
21. I hereby certify that I attended the deceased from 19, to 19; that I last saw h alive on 19; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death	
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations
Of autopsy

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? (Specify type of place)
While at work? (e) Means of injury
23. Signature (M. D. or other)
Address Date signed

SUPPLEMENTARY

14921