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5-17-39  
X37823

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

29532

State File No. ....

Registrar's No. ....

FILED SEP 23 1946

Registration District No. 36

Primary Registration District No. 4048

1. PLACE OF DEATH:

(a) County Boone

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

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

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

In this community Since July 11, 1946  
years, months or days

3. (a) PRINT FULL NAME Deane Pipes Benjamin

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 A. H. Benjamin

6. (c) Age of husband or wife if alive 54 years

7. Birth date of deceased May 24, 1892  
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>54</u>	<u>3</u>	<u>12</u>	hr. <u>---</u> min. <u>---</u>

9. Birthplace Howard Co. Missouri  
(City, town, or county) (State or foreign country)

10. Usual occupation Bookkeeper

11. Industry or business -----

MOTHER FATHER { 12. Name J. H. Pipes

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

14. Maiden name Louis Lee Drake

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

16. (a) Informant Drake Pipes

(b) Address Mexico, Missouri

17. (a) Removal (b) Date thereof 9/6/46  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Park Memorial Cemetery

18. (a) Signature of funeral director Ralph A. Carr  
Fayette, Missouri

(b) Address \_\_\_\_\_

19. (a) Oct 8, 1946 (b) Marion H. Angell  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Boone 10

(c) City or town Rocheport  
(If outside city or town limits, write "RURAL") 0

(d) Street No. \_\_\_\_\_  
(If rural, give location) 0

(e) Citizen of foreign country? No. (Yes/No)

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month September 6, 1946  
year 1946 hour 5 minute A. M.

21. I hereby certify that I attended the deceased from Aug. 13  
1946 to Aug 31 1946  
that I last saw her alive on Aug 31 1946  
and that death occurred on the date and hour stated above.

Immediate cause of death Chronic myocarditis

Due to facial infection

Due to \_\_\_\_\_

Other conditions chronic cholecystitis  
(Include pregnancy within 3 months of death)

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

Of autopsy 193D

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? Y

23. Signature Harry W. Griffith  
Address Calumet Mo Date signed 9-12-46  
(M.D. or other)

Duration \_\_\_\_\_

PHYSICIAN \_\_\_\_\_

Underline the cause to which death should be charged statistically.

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

**RECEIVED**

District Health Officer No. 9,

District File Number 9-46-175

Date Filed 9-23-46

**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 Ralph A Carr.....

Licensed Embalmer No. 3340.....

P. O. Address Jayette Mo......

**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. 36

Primary Registration District No. 4648

1. PLACE OF DEATH:

(a) County Boone

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

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

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

In this community Columbia, Mo. (Specify whether \_\_\_\_\_ years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County Boone

(c) City or town Rockport  
(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 Deane P. Benjamin

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb year 1946 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

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

Duration \_\_\_\_\_

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

6. (b) Name of husband or wife ARTHUR 6. (c) Age of husband or wife if same as hers (about) alive \_\_\_\_\_ years

7. Birth date of deceased May 24 (Month) (Day) (Year)

8. AGE: Years 54 Months 3 Days \_\_\_\_\_ (Unless than one day) hr. \_\_\_\_\_ min.

9. Birthplace Howard Co. Mo (City, town, or county) (State or foreign country)

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

MOTHER FATHER

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

12. Name W. H. Piper

13. Birthplace Howard Co. Mo (City, town, or county) (State or foreign country)

14. Maiden name Lou Drake

15. Birthplace Howard Co Mo (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 Memorial Park, Columbia Mo

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

19. (a) Oct-8-1946 (Date received local registrar) (b) Mrs. M. H. Angel (Registrar's signature)

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? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury \_\_\_\_\_

23. Signature J. C. Suggell (M. D. or other) \_\_\_\_\_ Address Columbia, Mo

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

SUPPLEMENTARY

29532