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FEDERAL SECURITY AGENCY

MISSOURI DIVISION OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. **32794**  
**3930**  
Registrar's No. \_\_\_\_\_

National Office of Vital Statistics  
**FILED NOV 4 1948**

Registration District No. 149

Primary Registration District No. 1002

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

**1. PLACE OF DEATH:**  
 (a) County Jackson  
 (b) City or town Kansas City  
(If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution:  
General Hospital No. 1  
(If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution 8 days  
(Specify whether  
 In this community 35 years  
years, months or days)

**2. USUAL RESIDENCE OF DECEASED:**  
 (a) State Missouri (b) County Jackson  
 (c) City or town Kansas City  
(If outside city or town limits, write "RURAL")  
 (d) Street No. 931 E. 11 St.  
(If rural, give location)  
 (e) Citizen of foreign country? NO. (Yes or No)  
 If yes, name country X

**3. (a) PRINT FULL NAME** Mrs. Goldie Benskin  
 3. (b) If veteran, name war no.  
 3. (c) Social Security No. NO.

**MEDICAL CERTIFICATION**  
 20. **DATE OF DEATH:** Month Sept. day 26  
 year 1948 hour 3 minute 40 P. M.  
 21. I hereby certify that I attended the deceased from  
Sept. 18, 1948, to Sept. 26, 1948,  
 that I last saw her alive on Sept. 26, 1948,  
 and that death occurred on the date and hour stated above.

4. Sex female / 5. Color or race white  
 6. (a) Single, widowed, married, divorced married  
 6. (b) Name of husband or wife William J. Benskin  
 6. (c) Age of husband or wife if alive Unknown years  
 7. Birth date of deceased June 8 1896  
(Month) (Day) (Year)

Immediate cause of death  
Far advanced tuberculosis with multiple lung abscesses  
 Duration \_\_\_\_\_

8. **AGE:** Years 52 Months 3 Days 18  
 If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

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

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

Other conditions (Include pregnancy within 3 months of death)  
13-48

10. Usual occupation at home

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

11. Industry or business X

12. Name DeLoose LaCore  
 13. Birthplace France  
(City, town, or county) (State or foreign country)  
 14. Maiden name Arina Olson  
 15. Birthplace Denmark  
(City, town, or county) (State or foreign country)

16. (a) Informant William J. Benskin

(b) Address 931 E. 11th St., Kansas City, Mo.

17. (a) burial (b) Date thereof 9-29-48  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Memorial Park  
Stine & McClure

18. (a) Signature of funeral director \_\_\_\_\_  
 (b) Address 3235 Gillham Plaza, K. C., Mo.

19. (a) 9-28-48 (b) Seraldine Holmes  
(Date received local registrar) (Registrar's signature)

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? D

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

23. Signature Wm W Hart (M. D. another) MA  
 Address Med. Dir. Gen'l Hosp. Date signed 9-27-48

*Dr. Durrell*

**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.....

*William L. Anderson*

Registered Apprentice No. *259*

working under my personal supervision.

Signed.....

*J. J. Allen*

Licensed Embalmer No. *1412*

P. O. Address *19 @ Mrs*

**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.**