

FILED JAN 26 1952

STANDARD CERTIFICATE OF DEATH 1003 State File No. 2582
REG. DIST. NO. 218 PRIMARY REG. DIST. NO. Registrar's No. 0433

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis	
c. LENGTH OF STAY (In this place) 4 wks		2149	
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Anthony Hospital		d. STREET ADDRESS (If rural, give location) 14 6305 Pernod Ave.	
3. NAME OF DECEASED a. (First) Oliver b. (Middle) J. c. (Last) Bene			4. DATE OF DEATH (Month) (Day) (Year) Jan. 14 1952
5. SEX M	6. COLOR OR RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Nov. 28, 1893
9. AGE (In years last birthday) 58		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Milk Salesman	11. BIRTHPLACE (State or foreign country) St. Louis, Mo.
10b. KIND OF BUSINESS OR INDUSTRY St. Louis Dairy		12. CITIZEN OF WHAT COUNTRY?	
13a. FATHER'S NAME James Bene		13b. MOTHER'S MAIDEN NAME Lillian Graseck	14. NAME OF HUSBAND OR WIFE Gertrude Bene
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME Gertrude Bene 6305 Pernod, St. Louis, Mo
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION 1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Metastatic Cancer of Prostate. DUE TO (b) Cancer of Prostate DUE TO (c) OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	
19a. DATE OF OPERATION Apr 1948		19b. MAJOR FINDINGS OF OPERATION Cancer of Prostate	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)	177XF
21d. TIME OF INJURY Nov 11 1952 m.	21e. INJURY OCCURRED WHILE AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? Fall on steps fracture of leg.	
22. I hereby certify that I attended the deceased from _____, 19____, and that death occurred at _____ A.M., from the causes and on the date stated above.			
23a. SIGNATURE John S. Warner M.D.		23b. ADDRESS 1115 Paul Boulevard St. Louis, Mo	23c. DATE SIGNED Jan 14 52
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 1-16-1952	24c. NAME OF CEMETERY OR CREMATORY St Pauls Churchyard	24d. LOCATION (City, town, or county) (State) St. Louis Mo
DATE REC'D BY LOCAL REG. JAN 15 1952	REGISTRAR'S SIGNATURE Earl Smith M.D.	25. FUNERAL DIRECTOR'S SIGNATURE C. HOFFMEISTER, COLONIAL MORTUARY 604 Chippewa St. St. Louis, Mo	

WRITE PLAINLY—USING UNFADEING BLACK INK—MAKE A PERMANENT RECORD

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.....

working under my personal supervision.

Student Embalmer No.....

Signed.....
Student Embalmer

Signed

Louis C. Hoffmann

Licensed Embalmer No. *3871*

P. O. Address *7814 S Broadway*

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.