

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

30670
STATE FILE NUMBER

FILED SEP 23 1957

Registration District No. 1 Primary Registration District No. 3000 Registrar's No. 332

1. PLACE OF DEATH a. COUNTY <u>Adair</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo</u> COUNTY <u>Sullivan</u>									
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Kirksville</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>Milan</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>							
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Grim-Smith M. Hosp</u>			Length of stay in 1b <u>2 weeks</u>		d. STREET ADDRESS (If outside, give location)		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>						
3. NAME OF DECEASED (Type or print) First <u>Alpha</u> Middle <u>Marie</u> Last <u>Bennett</u>				4. DATE OF DEATH Month <u>9</u> Day <u>13</u> Year <u>57</u>									
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>12-16-1908</u>		9. AGE (In years last birthday) <u>51</u>		IF UNDER 1 YEAR Month <u>5</u> Days <u>8</u> Hours <u>27</u> Min.		IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Keeper</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <u>Milan - Mo</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>				
13. FATHER'S NAME <u>Pete Bennett</u>						14. MOTHER'S MAIDEN NAME <u>Lizzie Kenton</u>							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>-</u>		17. INFORMANT Address <u>Dorothy Sayre - Milan Mo</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinomatosis</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <u>Cancer of ovary</u> DUE TO (c) <u>175X</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										INTERVAL BETWEEN ONSET AND DEATH <u>8 weeks</u>			
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)										
20c. TIME OF INJURY Hour <u>-</u> Month <u>-</u> Day <u>-</u> Year <u>-</u> a. m. <u>-</u> p. m. <u>-</u>													
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)			20f. CITY, TOWN, OR LOCATION COUNTY STATE							
21. I attended the deceased from <u>August 3, 1957</u> to <u>Sept. 13, 1957</u> and last saw her alive on <u>Sept. 13, 1957</u> Death occurred at <u>Kirksville, Mo. 7 p.m.</u> on the date stated above; and to the best of my knowledge, from the causes stated.													
22a. SIGNATURE (Degree or title) <u>O. L. Schroenes M.D.</u>					22b. ADDRESS <u>Grim-Smith Clinic & Hospital, Kirksville, Mo.</u>					22c. DATE SIGNED <u>Sept. 13, 1957</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			23b. DATE <u>9-15-57</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Oakwood Cem</u>				23d. LOCATION (City, town, or county) (State) <u>Milan - Mo</u>				
24. FUNERAL DIRECTOR <u>Schroenes August Schreuel</u> ADDRESS <u>Milan - Mo</u>					25. DATE RECD. BY LOCAL REG. <u>9-19-1957</u>			26. REGISTRAR'S SIGNATURE <u>Dora W. Ratliff</u>					

(Licensed Embalmer's Statement on Reverse Side)

diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes. USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE.

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, Student Embalmer No. working under my personal supervision.

Student
Signature of Student Embalmer

Signed..... *Dwight Dehaene*
Licensed Embalmer No. *26*

P. O. Address..... *W. Va.*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. to comply with the above constitutes grounds for revocation of license).
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.