

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

23150-57

58-010508  
STATE FILE NUMBER

FILED MAR 25 1958

Registration District No. 170 Primary Registration District No. 3033 Registrar's No. 52

300  
1-57

1. PLACE OF DEATH a. COUNTY <u>Laclede</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Laclede</u>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Lebanon</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Lynchburg</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Louise G. Wallace</u>		Length of stay in 1b <u>6 hours</u>	d. STREET ADDRESS (If outside, give location) <u>NONE</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Dallas</u> Middle <u>Bennett, Jr.</u> Last <u>Bennett, Jr.</u>			4. DATE OF DEATH Month <u>3</u> Day <u>18</u> Year <u>1958</u> am		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</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>4/15/1957</u>	9. AGE (In years last birthday) IF UNDER 1 YEAR: Months <u>11</u> Days <u>3</u> IF UNDER 24 HRS.: Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	11. BIRTHPLACE (City and state or country) <u>Lebanon, Missouri</u>		12. CITIZEN OF WHAT COUNTRY? <u>usa</u>
13a. FATHER'S NAME <u>Dallas Bennett, Sr.</u>		13b. MOTHER'S MAIDEN NAME <u>Bertha Gettings</u>		14. NAME OF HUSBAND OR WIFE <u>None</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>none</u>	17. INFORMANT Address <u>Wallace Hospital, Lebanon, Missouri</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>Pneumonia, bilateral</u>					INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) _____ DUE TO (c) _____					<u>490X</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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.) <u>0</u>		
20c. TIME OF INJURY Hour _____ a.m. _____ p.m. _____					
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>3-17-58</u> to <u>3-18-58</u> and last saw <sup>her</sup> <sub>him</sub> <u>live</u> on <u>3-18-58</u> Death occurred at <u>9:20</u> a <u>a</u> m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <u>W. Carrington, M.D.</u>			22b. ADDRESS <u>Lebanon, Mo.</u>		22c. DATE SIGNED <u>3-20-58</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>March 21, 1958</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Dorris</u>		23d. LOCATION (City, town, or county) (State) <u>Wright County, Missouri</u>	
24. FUNERAL DIRECTOR ADDRESS <u>E. J. Shadd Lebanon, Mo</u>		25. DATE RECD. BY LOCAL REG. <u>3-20-1958</u>	26. REGISTRAR'S SIGNATURE <u>Hella L. Gray</u>		

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be related. All diseases in Part I must be causally related.

Received MAR 24 1958

Laclede County Health Unit

File No. 52

Date Filed MAR 24 1958

### 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 B. D. Danbury

Licensed Embalmer No. 3874

P. O. Address. St. Louis, 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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.

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