

Health,  
Welfare  
Public  
Service

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-045175

STATE FILE NUMBER

FILED DEC 16 1958

Registration District No. 280 Primary Registration District No. 4423 Registrar's No. 88

300  
1-57

1. PLACE OF DEATH a. COUNTY <u>Platte</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Platte</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR <u>Weston</u> TOWN		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR <u>Iatan</u> TOWN <u>0930</u>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Matthew's Home</u>		Length of stay in lb <u>one Mt.</u>	d. STREET ADDRESS (If outside, give location) <u>—</u>
			Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>Benjamin</u> Middle <u>R.</u> Last <u>Daley</u>	4. DATE OF DEATH Month <u>Dec.</u> Day <u>2</u> Year <u>1958</u>
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5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> 3 DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 28, 1903</u>	9. AGE (In years last birthday) <u>55</u>	IF UNDER 1 YEAR Months <u>—</u> Days <u>—</u>	IF UNDER 24 HRS. Hours <u>—</u> Min. <u>—</u>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Foundry</u>	11. BIRTHPLACE (City and state or country) <u>Huron, Kans</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
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13a. FATHER'S NAME <u>James Daley</u>	13b. MOTHER'S MAIDEN NAME <u>Blanch Davis</u>	14. NAME OF HUSBAND OR WIFE
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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>500-07-1985</u>	17. INFORMANT <u>Mrs. Blanch Engerson</u>	Address <u>Iatan, Mo.</u>
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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>Cor Pulmonale</u>		INTERVAL BETWEEN ONSET AND DEATH <u>6 mo</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>Right &amp; Left Ventricular hypertrophy 2yrs</u>	
	DUE TO (c) <u>Pulmonary emphysema &amp; Fibrosis</u> <u>10yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>5271</u>		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.)
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20c. TIME OF INJURY Hour <u>—</u> Month, Day, Year a.m. <u>—</u> p.m. <u>—</u>	20d. INJURY OCCURRED WHILE AT WORK <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 <u>Weston, Mo</u>	COUNTY <u>Platte</u>	STATE <u>Mo</u>
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21. I attended the deceased from Death occurred at <u>3:30</u> <u>May 58</u> to <u>Dec 2-58</u> and last saw him alive on <u>Dec 2 1958</u> P. m on the date stated above; and to the best of my knowledge, from the causes stated.
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22a. SIGNATURE <u>R. J. Felling D.O.</u>	22b. ADDRESS <u>Weston, Mo</u>	22c. DATE SIGNED <u>12-3-58</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>12-5-1958</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Bethel Cem.</u>	23d. LOCATION (City, town, or county) (State) <u>Platte Co. Mo.</u>
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24. FUNERAL DIRECTOR <u>Vaughn Funeral Home</u>	ADDRESS <u>Weston, Mo</u>	25. DATE RECD. BY LOCAL REG. <u>12-5-1958</u>	26. REGISTRAR'S SIGNATURE <u>B. Phia Roelins</u>
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USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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



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 *W. R. Vaughn* .....

Licensed Embalmer No. *4023* .....  
P. O. Address *Weston 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.