

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-004246

STATE FILE NUMBER

FILED JAN 27 1959

Registration District No. 360

Primary Registration District No. 6225

Registrar's No. 11

300
-57

1. PLACE OF DEATH a. COUNTY <u>VERNON</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY <u>JASPER</u>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>WASHINGTON TOWNSHIP</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	c. CITY OR TOWN <u>CARTERSVILLE</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>STATE HOSPITAL NEVADA MO 17 1/2 MI, 6225</u>		Length of stay in 1b	d. STREET ADDRESS (If outside, give location) <u>205 ELM</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>WILLIAM</u> Middle <u>MITCHELL</u> Last <u>BENTON</u>			4. DATE OF DEATH Month <u>JAN.</u> Day <u>16.</u> Year <u>1959</u>		
5. SEX <u>MO</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>UNBORN 1922</u>	9. AGE (In years last birthday) <u>± 36</u>	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>NONE</u>	11. BIRTHPLACE (City and state or country) <u>LAWRENCE CO. MO</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>
13a. FATHER'S NAME <u>UNKNOWN</u>		13b. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>		14. NAME OF HUSBAND OR WIFE <u>OFFIE ANN BENTON</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>UNKNOWN</u>		16. SOCIAL SECURITY NO. <u>---</u>	17. INFORMANT Address <u>HOSP. RECORDS STATE HOSP. NEVADA 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>HYPOMATIC PNEUMONIA</u>					INTERVAL BETWEEN ONSET AND DEATH <u>2 DAYS</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>CARDIO-VASC. RENAL ART. SCLER. DISEASE</u>					<u>4 YEARS</u>
DUE TO (c) <u>---</u>					<u>---</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>GENERALIZED ART. SCLEROSIS</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.) <u>---</u>			
20c. TIME OF INJURY Hour <u>---</u> Month, Day, Year <u>---</u> a.m. <u>---</u> p.m. <u>---</u>		20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> WORK NOT WHILE AT WORK <input type="checkbox"/>			
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>---</u>		20f. CITY, TOWN, OR LOCATION <u>---</u>		COUNTY <u>---</u>	STATE <u>---</u>
21. I attended the deceased from <u>DEC. 10. 1959</u> to <u>JAN. 16. 1959</u> and last saw her alive on <u>JAN. 16. 1959</u> Death occurred at <u>8:30 P.M.</u> on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <u>[Signature]</u> (Degree or title)			22b. ADDRESS <u>STATE HOSP. NEVADA MO</u>		22c. DATE SIGNED <u>JAN. 16. 1959</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>1-18-1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Halltown Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Halltown Missouri</u>	
24. FUNERAL DIRECTOR <u>Hedge-ewis Funeral Home, Webb City Mo.</u>		ADDRESS	25. DATE RECD. BY LOCAL REG. <u>1-19-1959</u>	26. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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 *Richard Gray Lewis*

Licensed Embalmer No. *4400*

P. O. Address *Wald City, N.C.*

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.