

Health,
Welfare
Public
Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-020687
STATE FILE NUMBER

FILED JUN 29 1959 Registration District No. 64 Primary Registration District No. 5242 Registrar's No. 37

300
-57

1. PLACE OF DEATH a. COUNTY Chariton Co.		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY Chariton	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Bee Branch TWP Bynumville		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	c. CITY OR TOWN Bee Branch TWP Bynumville
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION R.F.D. 2		Length of stay in lb 12 yrs.	d. STREET ADDRESS R.F.D. 2

3. NAME OF DECEASED (Type or print) First Middle Last Benjamin J. Essig			4. DATE OF DEATH Month Day Year 6/20/1959		
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/7/1890	9. AGE (In years last birthday) 69	IF UNDER 1 YEAR Months Days 4 13
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Same	11. BIRTHPLACE (City and state or country) Salisbury, Mo.	12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13a. FATHER'S NAME Daniel		13b. MOTHER'S MAIDEN NAME Rebecca Jenson		14. NAME OF HUSBAND OR WIFE Lydia	
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 Address Mrs Lydia Essig Bynumville, Mo.	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hepatic carcinoma		INTERVAL BETWEEN ONSET AND DEATH 4 mo.
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c)		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		

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.) 1561	
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year		

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 COUNTY STATE
21. I attended the deceased from June 1st, 1959 to June 20, 1959 and last saw him alive on June 20, 1959 Death occurred at 11:40 PM on the date stated above; and to the best of my knowledge, from the causes stated.		

22a. SIGNATURE John Otto Carr D.O.	(Degree or title) 2	22b. ADDRESS 124 W. Ritchie, Marceline	22c. DATE SIGNED 6/22/59
23a. BURIAL, CREMATION, REMOVAL (Specify) B	23b. DATE 6/23/1959	23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet	23d. LOCATION (City, town, or county) Mo. (State) Marceline, Mo.

24. FUNERAL DIRECTOR James McLaughlin	ADDRESS Marceline, Mo	25. DATE RECD. BY LOCAL REG. 6-26-59	26. REGISTRAR'S SIGNATURE G.W. Hawkins
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USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

5-0

JUL 20 1960

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 *Gerald I. Wade*

Licensed Embalmer No. *4172*

P. O. Address *Brown*

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.