

R.I. DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-032985

FILED VS OCT 13 1959

Registration District No. 184 Primary Registration District No. 3038 Registrar's No. 106

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>Lenn</u>				2. USUAL RESIDENCE (Where deceased lived if institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>Lenn</u>				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Brookfield</u>		Length of stay in 1b <u>2 yrs</u>		c. CITY OR TOWN <u>Brookfield</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>Brookfield Nursing Home</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>Lan Pease Hotel</u>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Walter Carl Bendery</u>				4. DATE OF DEATH <u>Oct 6 1959</u>				
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <u>May 10, 1893</u>		
9. AGE (last birthday) <u>66</u>		IF UNDER 1 YEAR Months <u>1</u> Day <u>26</u> Hours <u></u> Min. <u></u>		IF UNDER 24 HR Hours <u></u> Min. <u></u>				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Delaware Railroad</u>			10b. KIND OF BUSINESS OR INDUSTRY <u></u>		11. BIRTHPLACE (City and state or country) <u>Babyma Mo</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13a. FATHER'S NAME <u>W. W. Bendery</u>			13b. MOTHER'S MAIDEN NAME <u>Mattie B. Webb</u>			14. NAME OF HUSBAND OR WIFE <u>Hazel Hopper Chillicothe Mo</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>707-07-6425</u>		17. INFORMANT <u>Hazel Hopper</u>		Address <u>Chillicothe Mo</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:							INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (a) <u>Cerebral aneurysm accident.</u>							<u>5 hours</u>	
DUE TO (b) <u>Generalized arteriosclerosis -</u>							<u>5 yrs.</u>	
DUE TO (c) <u></u>								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Memori</u>							PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
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 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.) <u>-</u>		20f. CITY, TOWN, OR LOCATION <u>-</u>		COUNTY <u>-</u> STATE <u>-</u>		
21. I attended the deceased from <u>1-31-57</u> to <u>10/6/59</u> and last saw her/him alive on <u>10-6-59</u> . Death occurred at <u>1:50 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>Katharine Johnson</u>				22b. ADDRESS <u>Brookfield Mo.</u>		22c. DATE SIGNED <u>10/8/59</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>Oct 8, 1959</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Gresham</u>		23d. LOCATION (City, town, or county) (State) <u>Brookfield Mo</u>		
24. FUNERAL DIRECTOR <u>Bowden's</u>		ADDRESS <u>Brookfield Mo</u>		25. DATE RECD. BY LOCAL REG. <u>10-8-59</u>		26. REGISTRAR'S SIGNATURE <u>Katharine Johnson rep</u>		

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by _____ or by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed James B. McCallan

Licensed Embalmer No. 4230

P. O. Address Brookfield

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to conform 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.