

REGISTRATION DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

60-000269

FILED VS FEB 8 1960

042 1000 132

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>Buchanan</u>		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Buchanan</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Joseph</u>		Length of stay in 1b <u>4 1/2 years</u>	c. CITY OR TOWN <u>St. Joseph</u>
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Mo. Methodist Hospital</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>3024 Dale Ave.</u>
3. NAME OF DECEASED (Type or print) First <u>Inez</u> Middle <u>Grace</u> Last <u>Benn</u>			4. DATE OF DEATH Month <u>Jan.</u> Day <u>30</u> Year <u>1960</u>
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</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>Dec. 22, 1892</u>
9. AGE (last birthday) <u>67</u>		IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>	11. BIRTHPLACE (City and state or country) <u>Martinsburg, Iowa</u>
12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>		13a. FATHER'S NAME <u>Francis O. Taylor</u>	
13b. MOTHER'S MAIDEN NAME <u>Sarah Virginia Porter</u>		14. NAME OF HUSBAND OR WIFE <u>Robert K. Benn</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 <u>Dr. R. K. Benn 3024 Dale Ave.</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>Blood dyscrasia, type undetermined</u> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			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 checked="" type="checkbox"/> NO <input 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.)	
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 <u>March 1959</u> to <u>Jan 30, 1960</u> and last saw <u>her</u> alive on <u>Jan 29, 1960</u> Death occurred at <u>5:30 A</u> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>G.T. Carpenter M.D.</u> (Degree or title)		22b. ADDRESS <u>902 Edmund</u>	22c. DATE SIGNED <u>3/2/60</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>Jan. 30, 1960</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Fairfield Cen.</u>	23d. LOCATION (City, town, or county) (State) <u>Fairfield, Iowa</u>
24. FUNERAL DIRECTOR <u>Clark Funeral Home</u> ADDRESS <u>St. Joseph, Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>Feb. 2, 1960</u>	26. REGISTRAR'S SIGNATURE <u>Mrs. Clark Landell</u>

DOCUMENT

BY AFFIDAVIT OF

G.T. Carpenter, M.D. Medical Certification

MAR 2 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
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Paul F. Clark

Licensed Embalmer No. 5024
P. O. Address St. Joseph, Mo.

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.