

FEDERAL DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-047083

FILED VS DEC 20 1960

Registration District No. 280 Primary Registration District No. 443 Registrar's No. 86

STATE FILE NUMBER

1. PLACE OF DEATH				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)			
a. COUNTY <b>Platte</b>		b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Weston,</b>		a. STATE <b>Mo.</b>		b. COUNTY <b>Platte</b>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Home (Weston, Mo;)</b>		Length of stay in lb <b>all of life</b>		c. CITY OR TOWN <b>Weston, Mo</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
d. STREET ADDRESS <b>Washington Ave.</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location)		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)				4. DATE OF DEATH			
First <b>CLARA</b>		Middle <b>ALMA</b>		Last <b>BENNER</b>		Month Day Year <b>December 7, 1960</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>7-31-1881</b>	9. AGE (last birthday) <b>79</b>	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) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>		11. BIRTHPLACE (City and state or country) <b>Weston, Mo.</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>	
13a. FATHER'S NAME <b>Casimir Moosman</b>			13b. MOTHER'S MAIDEN NAME <b>Augusta Kurtz</b>		14. NAME OF HUSBAND OR WIFE <b>L. B. Benner</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)   (If yes, give war or dates of service) <b>no none</b>		16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT Address <b>Earl B. Benner Leavenworth, Kans.</b>			
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) <b>Malnutrition; inability to swallow</b>						<b>1 week</b>	
DUE TO (b) <b>Cerebral thrombosis</b>						<b>13 years</b>	
DUE TO (c) <b>Hypertension</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Pyelitis and cystitis</b>						PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> N <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.)				
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 <b>Nov. 30, 1960</b> to <b>Dec. 6, 1960</b> and last saw <u>her</u> alive on <b>Dec. 6, 1960</b> Death occurred at <b>6:30 A</b> m on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <b>Lewis C. Colvick M.D.</b>				22b. ADDRESS <b>Weston, Missouri</b>		22c. DATE SIGNED <b>12-7-60</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>12-9-60</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Laurel Hill Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Weston, Mo</b>		
24. FUNERAL DIRECTOR ADDRESS <b>Vaughn Funeral Home Weston, Mo.</b>				25. DATE RECD. BY LOCAL REG. <b>12.9.1960</b>		26. REGISTRAR'S SIGNATURE <b>Opelia Rollins</b>	

(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

*W. R. Vaughn*

Licensed Embalmer No. X02

P. O. Address Weston

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.