

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-037996

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

STATE FILE NUMBER

AMENDED

Registration District No. 275 Primary Registration District No. 3053 Registrar's No. 223

FILED OCT 24 1961

1. PLACE OF DEATH a. COUNTY <u>Phelps</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Phelps</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Rolla</u>		c. CITY OR TOWN <u>Cuba</u>	
c. FULL NAME OF (If not in hospital, give location) HOSPITAL OR INSTITUTION <u>McFarland Nursing Home</u>		d. STREET ADDRESS (If outside, give location) <u>Rural</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Phenice C. Benton</u>		4. DATE OF DEATH Month Day Year <u>October 14, 1961</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>4-7-1877</u>
9. AGE (last birthday) <u>89</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>Home</u>	11. BIRTHPLACE (City and state or country) <u>Mission Kansas</u>
12. CITIZEN OF WHAT COUNTRY <u>USA</u>		13a. FATHER'S NAME <u>Adolphus Meyer</u>	
13b. MOTHER'S MAIDEN NAME <u>Josephine Cooper</u>		14. NAME OF HUSBAND OR WIFE <u>Samuel W. Benton.</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>xx</u>	
17. INFORMANT <u>Samuel W. Benton, Cuba, Mo.,</u>		Address	
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>Terminal 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>Fall causing fracture of rt hip.</u>			<u>2 days.</u>
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Senility</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 checked="" 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>Fell at m & Farland nursing home, slipped on floor + fall</u>	
20c. TIME OF INJURY Hour a.m. p.m. <u>10-12-61</u>	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>m & Farland nursing home</u>		20f. CITY, TOWN, OR LOCATION <u>Rolla</u>	COUNTY <u>Phelps</u> STATE <u>mo</u>
21. I attended the deceased from <u>8-9-1957</u> , to <u>10-14-61</u> and last saw her/him alive on <u>10-13-61</u> Death occurred at <u>4 P</u> m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>E. E. Feind, M.D.</u>		22b. ADDRESS <u>Rolla, Mo.</u>	22c. DATE SIGNED <u>10-16-61</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>10-17-61</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Steelville Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Steelville, Missouri.</u>
24. FUNERAL DIRECTOR ADDRESS <u>Shanklin Funeral Home, Cuba, Mo.,</u>		25. DATE RECD. BY LOCAL REG. <u>Oct. 16, 1961</u>	26. REGISTRAR'S SIGNATURE <u>Nadene L. Stoll</u>

DATE AMENDED

INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

OCT 25 1961

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



Licensed Embalmer No. 3472

P. O. Address Cuba, Mo.

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.