

FILED OCT 27 1944

Registration District No. **4/2**

Primary Registration District No. **1000**

1. PLACE OF DEATH:

(a) County **Buchanan**
 (b) City or town **St Joseph**
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
Approx 32nd & Fred Ave.
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution _____
 In this community **2 yrs** **3** (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Buchanan**
 (c) City or town **111 No 10th**
(If outside city or town limits, write "RURAL")
 (d) Street No. **St Joseph**
(If rural, give location)
 (e) Citizen of foreign country? **No** **0** (Yes or No)
 If yes, name country _____

3. (a) PRINT FULL NAME **Benton Lee Everett**

3. (b) If veteran, name war _____ 3. (c) Social Security No. **499-20-2008**

4. Sex **Male** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **Single**

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased **Mar. 5 1928**
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	16	7	9	hr. min.

9. Birthplace **Andrew Co. Mo**
(City, town, or county) (State or foreign country)

10. Usual occupation **School worked Extra**

11. Industry or business **in Cafes etc.**

12. Name **Myron E Everett**

13. Birthplace _____
(City, town, or county) (State or foreign country)

14. Maiden name **Etta Wheeler**

15. Birthplace **Dekalb Co Mo**
(City, town, or county) (State or foreign country)

16. (a) Informant **Etta Everett**

(b) Address **St Joseph, Mo**

17. (a) **Burial** (b) Date thereof **10-17-44**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Memorial Park**

18. (a) Signature of funeral director **Fleeman & Son Inc**

(b) Address **St Joseph, Mo**

19. (a) **10-17-44** (b) **G. W. J. Puckler**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Oct** day **14**
 year **1944** hour **11** minute **40 P.M.**

21. I hereby certify that **viewed** the deceased **from P.M.**
Oct 15th 19**44** to _____, 19____;

that I last saw him _____ alive on _____, 19____;
 and that death occurred on the date and hour stated above.

Immediate cause of death: **Basal Skull fracture, fatal cerebral hemorrhage and shock.**
 Due to _____

Due to **Fracture of left leg.**
 Due to _____

Other conditions **man was struck and killed by an auto-**
(Include pregnancy within 3 months of death)

Major findings: **mobile driven by another on Freidrich Blvd**
 Of autopsy **no in St Joseph Mo**

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) **Accident** **121**

(b) Date of occurrence **10-14-44**

(c) Where did injury occur? **St Joseph Buchanan Mo**
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?
Public Street - US #36 Highway
(Specify type of place)
 While at work? **No.** (e) Means of injury **Automobile**

23. Signature **H. T. Moody** (M. D. **Coroner**)

Address **404 1/2 St** Date signed **10/16/44**

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

MOTHER, FATHER

Duration **1 day**
 Physician _____
 Underline the cause to which death should be charged statistically.

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

.....
Registered Apprentice No.

working under my personal supervision.

Signed

Robert H. Geph

Licensed Embalmer No.

3308

P. O. Address

St Joseph, 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 this body is not embalmed, fact should be so stated above.