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DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE — PUBLIC HEALTH SERVICE

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DEPARTMENT OF PUBLIC HEALTH CERTIFICATE OF DEATH STATE OF TENNESSEE

DIVISION OF VITAL STATISTICS

BIRTH NO. 756.2

DEATH NO. 2365

1. NAME: Scott (First) Alexander (Middle) Bender (Last)

2. DATE OF DEATH: 5-28-59 (Month Day Year)

3. COLOR OR RACE: W

4. SEX: M

5. SINGLE, MARRIED, WIDOWED, DIVORCED (SPECIFY): Single

6. DATE OF BIRTH: 3-20-59 (Month Day Year)

7. AGE (IN YEARS LAST BIRTHDAY): IF UNDER 1 YR. Months: 2 Days: 8; IF UNDER 24 HRS. Hours: Mins.:

8. PLACE OF DEATH
A. COUNTY: Shelby
B. CIVIL DISTRICT:
C. CITY OR TOWN: Memphis
D. LENGTH OF STAY IN THIS PLACE: 2mo 8days
E. NAME OF HOSPITAL OR INSTITUTION (If not in Hospital or Institution, Give Street Address or Location): Le Bonheur Hosp.
F. INSIDE CITY LIMITS? YES [X] NO [ ]

9. USUAL RESIDENCE OF DECEASED (Where Deceased Lived. If Institution, Residence Before Admission)
A. STATE: Tenn. B. COUNTY: Shelby C. CIVIL DISTRICT: 086
D. CITY OR TOWN: Memphis
E. INSIDE CITY LIMITS? YES [X] NO [ ]
F. STREET ADDRESS (OR LOCATION): 4419 Sequoia
G. IS RESIDENCE ON A FARM? YES [ ] NO [X]

10A. USUAL OCCUPATION (Kind of Work Done During Most of Working Life, Even if Retired): Infant
10B. KIND OF BUSINESS OR INDUSTRY:
11. SOCIAL SECURITY NUMBER:
12. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) IF YES, GIVE WAR OR DATES OF SERVICE:
13. BIRTHPLACE (State or Foreign Country): Tennessee
14. CITIZEN OF WHAT COUNTRY? U. S. A.
15. NAME OF HUSBAND OR WIFE:
16. FATHER'S NAME: Charles Anthony Bender
17. MOTHER'S MAIDEN NAME: Louisa Scott
18. INFORMANT: chart ADDRESS:

MEDICAL CERTIFICATION

INTERVAL BETWEEN ONSET AND DEATH

19. CAUSE OF DEATH
Enter only one cause per line for (A), (B), (C).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (A): Duodenal ATRESIA — 10 hr
DUE TO (B): MALROTATION OF MIDGUT. — 10 hr
Conditions, if any, which gave rise to above cause (A); stating the underlying cause last
DUE TO (C):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO TERMINAL DISEASE CONDITION GIVEN IN PART I (A)

20. WAS AUTOPSY PERFORMED? YES [ ] NO [ ]

21A. ACCIDENT [ ] SUICIDE [ ] HOMICIDE [ ]
21B. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 19)
21C. TIME OF INJURY: HOUR A.M. P.M. MO. DAY YR.
21D. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21E. PLACE OF INJURY (In or About Home, Farm, Factory, Street, Office Building, etc.)
21F. PLACE OF INJURY CITY, TOWN OR RURAL COUNTY STATE

22. I HEREBY CERTIFY THAT THE DECEASED DIED ON THE DATE AND FROM THE CAUSE STATED ABOVE
SIGNATURE: Robert C. Allen M.D. [X] D.O. [ ] OTHER (SPECIFY)
ADDRESS: LeBonheur Hosp.
DATE: 5-28-59

23A. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial
23B. DATE OF BURIAL, CREMATION OR REMOVAL: 5-29-59
23C. NAME OF Cemetery or Crematory: Forest Hill
23D. LOCATION CITY, TOWN OR COUNTY STATE: Memphis Tenn.

24. FUNERAL DIRECTOR ADDRESS: National Funeral Home--Memphis
25. REGISTRATION DIST. NO.: 791
26. DATE SIGNED BY LOCAL REG.: JUN 1 - 1959
27. REGISTRAR'S SIGNATURE: L. M. Graves
By Rose Sackett