WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

1 PLACE OF DEATH

County .....

Township ..... or Village ..... or City St Louis

Registration District No. 791 File No. 30817

Primary Registration District No. 1003 Registered No. 8728

(No. St John's Hospital St. 25 Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Rose E Banister

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE White

5 SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) Sing

6 DATE OF BIRTH May (Month) 29 (Day), 1855 (Year)

7 AGE 63 yrs. 3 mos. 20 ds. If LESS than 1 day, ... hrs. or ..... min.?

8 OCCUPATION (a) Trade, profession, or particular kind of work Private Secretary

(b) General nature of industry business, or establishment in which employed (or employer) .....

9 BIRTHPLACE (City or town, State or foreign country) Cleveland Ohio

PARENTS

10 NAME OF FATHER John M Banister

11 BIRTHPLACE OF FATHER (City or town, State or foreign country) England

12 MAIDEN NAME OF MOTHER Miriam Sparks

13 BIRTHPLACE OF MOTHER (City or town, State or foreign country) England

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Fred. A Banister

(Address) 4542 W Pine

15 Filed SEP 29 1918 Max C Starkoff Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Sept (Month) 18 (Day), 1918 (Year)

17 I HEREBY CERTIFY, that I attended deceased from June 1, 1918, to Sept 18, 1918

that I last saw her alive on Sept 18, 1918

and that death occurred, on the date stated above, at 11:15 a.m.

The CAUSE OF DEATH* was as follows:

Cancer of intestine

41 C

(Duration) ..... yrs. 4 mos. ..... ds.

CONTRIBUTORY (Secondary) No

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Jno M Ford M.D.

Sept 18 1918 (Address) 536 N. Taylor

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death ..... yrs. 1 mos. 21 ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted if not at place of death? .....

Former or usual residence 5152 Cabany

19 PLACE OF BURIAL OR REMOVAL Bellefontaine

DATE OF BURIAL Sept 19, 1918

20 UNDERTAKER Akron L & U Co

ADDRESS 2707 N Grand

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

1 PLACE OF DEATH

County .....

Township ..... Registration District No. ..... File No. .....
or
Village ..... Primary Registration District No. ..... Registered No. .....
or
City ..... (NO. ....., ... St.; ..... Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME .....

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE MARRIED WIDOWED OR DIVORCED (*Write* the word)

6 DATE OF BIRTH
..... (Month) ..... (Day) ....., 1..... (Year)

7 AGE
.....yrs. ..... mos. ..... ds.

If LESS than 1 day, ... hrs. or ..... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work .....
(b) General nature of industry business, or establishment in which employed (or employer) .....

9 BIRTHPLACE
(City or town, State or foreign country)

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER
(City or town, State or foreign country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER
(City or town, State or foreign country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) .....

(Address) .....

15

Filed ....., 191....., ...
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH
..... (Month) ..... (Day) ....., 191..... (Year)

17 I HEREBY CERTIFY, that I attended deceased from ....., 191....., to ....., 191.....
that I last saw h.....alive on ....., 191.....
and that death occurred, on the date stated above, at .....m.
The CAUSE OF DEATH* was as follows:

.....
.....
.....
..... (Duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY .....
(Secondary)
..... (Duration) .....yrs. .....mos. .....ds.

(Signed) ..... M. D.
....., 191..... (Address) .....

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death .....yrs. .....mos. .....ds. In the State .....yrs. .....mos. .....ds.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL ....., 191.....
20 UNDERTAKER	ADDRESS

LOCAL REGISTRAR'S RECORD—DO NOT TEAR LEAF OUT

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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