Johnson

# LOCAL REGISTRAR'S RECORD—DO NOT TEAR LEAF OUT

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

3562 c

1. PLACE OF DEATH
County: Dallas — Registration District No.: 24 — File No.:
Township: N. Benton — Primary Registration District No.: 5334 — Registered No.: (17)
City: ~~Buffalo Mo.~~ ... St. ... Ward)

2. FULL NAME: Seth Banks

(a) Residence. No. ... St., ... Ward. ...
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX: male
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): Single

5A. IF MARRIED, WIDOWED, OR DIVORCED
~~HUSBAND OF~~ (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR): 9/15

7. AGE: Years 68 | Months | Days | If LESS than 1 day, ... hrs. or ... min.

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

9. BIRTHPLACE (CITY OR TOWN): Ohio
(STATE OR COUNTRY)

PARENTS
10. NAME OF FATHER: Seth S. Banks
11. BIRTHPLACE OF FATHER (CITY OR TOWN): Maine
(STATE OR COUNTRY)
12. MAIDEN NAME OF MOTHER: Smith
13. BIRTHPLACE OF MOTHER (CITY OR TOWN): Penn.
(STATE OR COUNTRY)

14. INFORMANT: David Bellmire
(Address): Buffalo, Mo.

15. FILED 12.13 19 21 [illegible] REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR): 2/11 1921

17. I HEREBY CERTIFY, That I attended deceased from Feb. 4, 1921, to Feb. 9, 1921, that I last saw him alive on Feb. 9, 1921, and that death occurred, on the date stated above, at 9 A.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Bronchial Pneumonia
10 DA
(duration) ... yrs. ... mos. 6 ds.
CONTRIBUTORY (SECONDARY) ...
(duration) ... yrs. ... mos. ... ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH? ...
DID AN OPERATION PRECEDE DEATH? No DATE OF No
WAS THERE AN AUTOPSY? No
WHAT TEST CONFIRMED DIAGNOSIS? ...
(Signed) B. F. Johnson, M. D.
, 19 (Address) Buffalo Mo

*State the DISEASE CAUSING DEATH, or if deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL: Union Home — DATE OF BURIAL: 2/12 1921
20. UNDERTAKER: Routh & Jones — ADDRESS: Buffalo, Mo.

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.

# LOCAL REGISTRAR'S RECORD—DO NOT TEAR LEAF OUT

## MISSOURI STATE BOARD OF HEALTH
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### CERTIFICATE OF DEATH

**1. PLACE OF DEATH**

County..... Registration District No..... File No.....

Township..... Primary Registration District No..... Registered No. .....

City..... (No....., ..... St. .....Ward)

**2. FULL NAME** .....

(a) Residence. No..... St., .....Ward. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX | 4. COLOR OR RACE | 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word)

5A. IF MARRIED, WIDOWED, OR DIVORCED
HUSBAND OF
(OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

7. AGE | YEARS | MONTHS | DAYS | If LESS than 1 day, .....hrs. or .....min.

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

9. BIRTHPLACE (CITY OR TOWN) .....
(STATE OR COUNTRY)

PARENTS

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (CITY OR TOWN).....
(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (CITY OR TOWN).....
(STATE OR COUNTRY)

14.
INFORMANT .....
(Address)

15.
FILED....., 19..... .....
REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) 19

17.
I HEREBY CERTIFY, That I attended deceased from .....
....., 19....., to ....., 19.....
that I last saw h..... alive on....., 19....., 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.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH?.....
DID AN OPERATION PRECEDE DEATH?..... DATE OF.....
WAS THERE AN AUTOPSY?.....
WHAT TEST CONFIRMED DIAGNOSIS?.....
(Signed)....., M. D
, 19 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL | DATE OF BURIAL 19

20. UNDERTAKER | ADDRESS

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.