

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

Do not use this space.

19347

1. PLACE OF DEATH
 County Jackson Registration District No. 399
 Township Kaw Primary Registration District No. 1002
 City Kansas City (No. General Hospital) St. _____ Ward _____

2. FULL NAME Mrs. Audrey Helen Banoy
 (a) Residence. No. 2317 Troost St. 4 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 Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) May 1, 1913

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
17 1 7

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work At Home
 (b) General nature of industry, business, or establishment in which employed (or employer)
 (c) Name of employer

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

10. NAME OF FATHER Jack Lain
 11. BIRTHPLACE OF FATHER (CITY OR TOWN) Unknown
 (STATE OR COUNTRY)
 12. MAIDEN NAME OF MOTHER Ollie Flannigan
 13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Unknown
 (STATE OR COUNTRY)

14. INFORMANT Bert Banoy
 (Address) 2317 Troost

15. FILED 6/3 19 30 M. M. Coroneel
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 6-2 1930

17. I HEREBY CERTIFY, That I attended deceased from _____ 19____ to _____ 19____
Deputy Coroner
 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:

Suicide, firearm

167 (duration) yrs. mos. ds.
 CONTRIBUTORY (SECONDARY) 170
 (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED
 IF NOT AT PLACE OF DEATH

0 DID AN OPERATION PRECEDE DEATH? DATE OF _____

WAS THERE AN AUTOPSY? Y

WHAT TEST CONFIRMED DIAGNOSIS History, Inspection
 (Signed) Stanley M. Hall M.D.

6/2 19 30 (Address) Deputy Coroner

*State the DISEASE CAUSING DEATH, in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) Whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Climax Springs, Mo. DATE OF BURIAL June 4 19 30

20. UNDERTAKER R.V. Lindsey & Sons, Inc ADDRESS Kans 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.

