

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

Do not use this space.

*Dr. Callaway*  
9485

**1. PLACE OF DEATH**

39 County Breezy Registration District No. 318  
Township \_\_\_\_\_ Primary Registration District No. 2901  
City Springfield, Mo. St. Johns Hospital File No. \_\_\_\_\_  
Registered No. 169 St. \_\_\_\_\_ Ward \_\_\_\_\_

**2. FULL NAME**

(a) Residence, No. Keystone Hotel 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) unknown

7. AGE YEARS MONTHS DAYS If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.  
about 62

8. Trade, profession, or particular kind of work done, as splinner, sawyer, bookkeeper, etc. Retd. Farmer  
9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. \_\_\_\_\_  
10. Date deceased last worked at this occupation (month and year) \_\_\_\_\_ 11. Total time (years) spent in this occupation \_\_\_\_\_

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Illinois

13. NAME \_\_\_\_\_

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) 31

15. MAIDEN NAME \_\_\_\_\_

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) \_\_\_\_\_

17. INFORMANT (ADDRESS) Dr. Wagoner  
Springfield, Mo.

18. BURIAL, CREMATION, OR REMOVAL PLACE Hazelwood DATE March 5 - 1931

19. UNDERTAKER (ADDRESS) Mrs. Lammert  
Springfield, Mo.

20. FILED 3-2-31 1931 Zon Sharp Registrar.

**MEDICAL CERTIFICATE OF DEATH**

21. DATE OF DEATH (MONTH, DAY, AND YEAR) March 3 - 1931

22. I HEREBY CERTIFY, That I attended deceased from Feb 7, 1931, to March 3, 1931  
I last saw him alive on March 2, 1931. Death is said to have occurred on the date stated above, at 11:30 A.M.  
The principal cause of death and related causes of importance were as follows:

Hemiplegia - (apoplexy)  
Pneumonia, hypostatic  
Date of onset Feb 2 1931

Other contributory causes of importance: \_\_\_\_\_  
Name of operation \_\_\_\_\_ Date of \_\_\_\_\_  
What test confirmed diagnosis? \_\_\_\_\_ Was there an autopsy? \_\_\_\_\_

23. If death was due to external causes (violence), fill in also the following:  
Accident, suicide, or homicide? \_\_\_\_\_ Date of injury \_\_\_\_\_, 19\_\_\_\_  
Where did injury occur? \_\_\_\_\_ (Specify city or town, county, and State)  
Specify whether injury occurred in industry, in home, or in public place. \_\_\_\_\_  
Manner of injury \_\_\_\_\_  
Nature of injury \_\_\_\_\_

24. Was disease or injury in any way related to occupation of deceased? \_\_\_\_\_  
If so, specify \_\_\_\_\_  
(Signed) Dr. Callaway, M. D.  
(Address) Springfield, Mo.

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.

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

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

**1. PLACE OF DEATH**

County Greene

Registration District No. 318

Township Springfield

Primary Registration District No. 2001

City Springfield (No. ....)

File No. ....

Registered No. 169

St. .... Ward)

**2. FULL NAME** Herman L. Banay

(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 M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) S.

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. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. ....  
 9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. ....  
 10. Date deceased last worked, at this occupation (month and year) ..... 11. Total time (years) spent in this occupation .....

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

13. NAME Unknown

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Unknown

15. MAIDEN NAME Unknown

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Unknown

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL PLACE ..... DATE ..... 19

19. UNDERTAKER (ADDRESS)

20. FILED 3-3 1931 Gon Sharp Registrar

**MEDICAL CERTIFICATE OF DEATH**

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Mar 3 - 1931

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..... to ....., 19.....

I last saw h..... alive on ....., 19..... Death is said

to have occurred on the date stated above, at ....., m.

The principal cause of death and related causes of importance were as follows:

.....  
 Other contributory causes of importance:  
 .....  
 Date of onset

Name of operation..... Date of.....

What test confirmed diagnosis?..... Was there an autopsy?.....

23. If death was due to external causes (violence), fill in also the following:

Accident, suicide, or homicide?..... Date of injury....., 19.....

Where did injury occur?..... (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury.....

Nature of injury.....

24. Was disease or injury in any way related to occupation of deceased?.....

If so, specify.....

(Signed) ....., M. D.

(Address) .....

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REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY W

SUPPLEMENTARY

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