

REC'D SEP 20 1939

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

28714
Do not use this space.

1. PLACE OF DEATH *Callaway*
(a) County.....
(b) Township..... *Fulton*
(c) City.....
(d) Street No. *State Hospital # 1* St. _____
(If death occurred in Hospital or institution, write its name instead of street and number)
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.
2. PRINT FULL NAME *Joseph Banks*
(a) Residence, No. *State Hospital # 1* St. (If nonresident, give city or town and State)
(Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *Female*
4. COLOR OR RACE *Black*
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) *MARRIED*
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF *E LHS BANKS*
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) *D.K.*
7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
63 DK D.K.
OCCUPATION
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. *Housewife*
9. Industry or business in which work was done, as saw mill, bank, etc. *Home*
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) *ARKANSAS*
13. NAME *D.K.*
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *D.K.*
15. MAIDEN NAME *D.K.*
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *D.K.*
17. INFORMANT (ADDRESS) *Hospital Record*
18. BURIAL, CREMATION, OR REMOVAL PLACE *Kirkville Mo* DATE *Aug 2 - 39*
19. FUNERAL DIRECTOR (NAME) (ADDRESS) *Leo G. Wallace*
Hulton Mo
20. FILED *Aug 2, 1939* *R. N. Crewe*
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *Aug 1st 1939*
22. I HEREBY CERTIFY That I attended deceased from *Feb 11, 1939* to *AUGUST 1, 1939*
I last saw him alive on *AUG 1, 1939* Death is said to have occurred on the date stated above, at *4 A* m.
The principal cause of death and related causes of importance were as follows:
Arteriosclerotic Heart Disease
Other contributory causes of importance: *95 lb?*
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) *Forrest Thomas* _____, M. D.
(Address) _____

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

....., Registered Apprentice No.....
working under my personal supervision.

Signed Harold J. Christey
Licensed Embalmer No. 4002
P. O. Address Belted, Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.