DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 39474

Registration District No. 2668 DEC 15 1939

Primary Registration District No. 4164

Registrar's No. 86

1. PLACE OF DEATH:

(a) County Dent

(b) City or town Salem 2nd (If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: V

(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution (Specify whether

In this community years, months or days) 5 D

2. USUAL RESIDENCE OF DECEASED:

(a) State 1 (b) County

(c) City or town (If outside city or town limits, write "RURAL")

(d) Street No. (If rural, give location)

(e) If foreign born, how long in U. S. A.? years.

8. (a) PRINT FULL NAME Clyde marvin Banks

8. (b) If veteran, name war

8. (c) Social Security No.

4. Sex Male

5. Color or race White

6. (a) Single, widowed, married, divorced "

6. (b) Name of husband or wife

6. (c) Age of husband or wife if alive years

7. Birth date of deceased 11 (Month) 3 (Day) 1939 (Year)

8. AGE: Years | Months | Days | If less than one day hr. 30 min.

9. Birthplace Salem (City, town, or county) Mo. (State or foreign country) 0

10. Usual occupation Infant 0

11. Industry or business 0

MOTHER FATHER

12. Name Sandd Marvin Banks 0

13. Birthplace Wayne (City, town, or county) Mo. (State or foreign country)

14. Maiden name Pearl Foy Kirk

15. Birthplace Texas Co. (City, town, or county) Mo. (State or foreign country)

16. (a) Informant's own signature Mrs Maurice Banks

(b) Address Salem Mo

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-4-1939 (Month) (Day) (Year)

(c) Place: burial or cremation Concordia Mo.

18. (a) Signature of funeral director H. D. Coleman

(b) Address Salem

19. (a) Nov 4 1939 (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month November day 3rd

year 1939 hour 3 PM minute M.

21. I hereby certify that I attended the deceased from , 19 , to , 19 ;

that I last saw him alive on Nov 3 , 1939

and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Malformation Baby lived about Thirty minutes after birth	
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations

Of autopsy

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify)

(b) Date of occurrence

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)

While at work? (e) Means of injury

23. Signature of D. E. Foley (M. D. or other) MD

Address Salem Mo. Date signed 11/4/39

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

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

Rev. 8-17-39 1 x10511

200L

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.

RECEIVED
District Health Officer No. 5,
District File Number 1239481
Date Filed 12/13/32

Signed.....

Licensed Embalmer No.....

P. O. Address.....

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.

FILL IN ANSWERS TO ALL SPACES CHECKED IN RED PENCIL.

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

39494
Do not use this space.

1. PLACE OF DEATH
(a) County Dent Registration District No. 266
(b) Township Primary Registration District No. 1164 Registered No. 86
(c) City Salem (d) Street No. 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 Clyde Marion Banks

(a) Residence, No. St.
(Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

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.

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)
M	W	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 30 min.

OCCUPATION
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.
9. Industry or business in which work was done, as 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)

FATHER
13. NAME
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

MOTHER
15. MAIDEN NAME
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL
PLACE DATE 19

19. FUNERAL DIRECTOR (ADDRESS)

20. FILED 19 Local Registrar.

SUPPLEMENTARY

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Nov 3 1939

22. I HEREBY CERTIFY, That I attended deceased from 19, 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:

	Date of onset
Baby lived about 30 minutes after birth. Child born with head covered by amniotic membrane (Caul) Delivery was slow, child was	

Other contributory causes of importance:
Have aspirated amniotic fluid after cord could be removed from head

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) D E Joseph, M. D.
(Address) Salem Mo