

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.

Registration District No. 723

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

40704

State File No. _____

Primary Registration District No. 6023

Registrar's No. 184

1. PLACE OF DEATH:
(a) County St. Francis. Randolph Co. Mo.
(b) City or town Doe Run.
(c) Name of hospital or institution: _____
(If outside city or town limits, write "RURAL" and name of township)
(If not in hospital or institution, write street number or location) at home
(d) Length of stay: In hospital or institution _____ (Specify whether _____)
In this community _____ years, months or days 523

2. USUAL RESIDENCE OF DECEASED:
(a) State _____ (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.

3. (a) PRINT FULL NAME BABY BANISTER. (Stillbirth)
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month November Day 24th
year 1939 hour _____ minute _____ M.

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced Infant
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____; that I last saw him _____ alive on _____, 19____; and that death occurred on the date and hour stated above.

7. Birth date of deceased: Nov. 24 1939
(Month) (Day) (Year)
8. AGE: Years _____ Months _____ Days _____ If less than one day Born Dead
hr. _____ min. _____

Immediate cause of death Stillbirth Duration _____
due to deformity of skull.
There was no skull from about
Due to an inch above eyes or no
covering over spinal cord down
Due to the first lumbar vertebrae.
Entire absence of Brain

9. Birthplace Doe Run Missouri
(City, town, or county) (State or foreign country)
10. Usual occupation _____
11. Industry or business _____

Other conditions _____ (Includes pregnancy within 3 months of death)
Major findings: _____
Of operations _____
Of autopsy None

MOTHER FATHER
12. Name Clarence Banister
13. Birthplace Doe Run Missouri.
14. Maiden name Birdie Reese (State or foreign country)
15. Birthplace Elvins, Missouri.
(City, town, or county) (State or foreign country)

PHYSICIAN _____
Underline the cause to which death should be charged statistically.

16. (a) Informant's own signature Clarence Banister
(b) Address Doe Run Mo
17. (a) Burial (b) Date thereof Nov 25, 39
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Doe Run Mo.

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? _____

18. (a) Signature of funeral director Richardson Funeral Ho
(b) Address Farmington Missouri
19. (a) Nov 29-39 (b) B. J. Robinson
(Date received local registrar) (Registrar's signature)

While at work? _____ (Specify type of place) (e) Means of injury _____
23. Signature L. M. Stanfield (M. D. or other) MD
Address Farmington, Mo. Date signed 11/27
1939

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.....

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.