

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.

MISSOURI STATE BOARD OF HEALTH

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

41022

Do not use this space.

1. PLACE OF DEATH

(a) County Sullivan Registration District No. 852
 (b) Township Jackson Primary Registration District No. 6124 Registered No. _____
 (c) City Ballou-R.F.D. (d) Street No. _____
 (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

(a) Residence, No. _____ 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 Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Separated
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Mary Belle
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Sept 26, 1864
 7. AGE YEARS 75 MONTHS 1 DAYS 29 If LESS than 1 day, hrs. or min.
 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Real Estate
 9. Industry or business in which work was done, as saw mill, bank, etc. Retired 5 years
 10. Date deceased last worked at this occupation (month and year) Nov 1933 11. Total time (years) spent in this occupation 30

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

Missouri

13. NAME

Ezekiel W. Banner

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

Ohio

15. MAIDEN NAME

Elija Wyrick

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

Ohio

17. INFORMANT (ADDRESS)

G. F. Banner
Pollock, Mo.

18. BURIAL, CREMATION, OR REMOVAL

PLACE Lemon Mo. DATE Nov. 27, 1939

19. FUNERAL DIRECTOR (NAME) (ADDRESS)

Cornstock Merc Co
Harrison Mo.

20. FILED Nov 26, 1939 Cleo Hagan
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Nov 25, 1939

22. I HEREBY CERTIFY, That I attended deceased from Nov. 20, 1939, to Nov. 26, 1939.

I last saw him alive on Nov. 24, 1939. Death is said to have occurred on the date stated above, at 11:20 A.M.

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

Chronic nephritis Date of onset Nov

Other contributory causes of importance:

Chronic hypertrophy, Colitis, Cystitis, Hemiplegia

Name of operation None Date of _____

What test confirmed diagnosis? Phys. Exam Was there an autopsy? No

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? No

If so, specify _____

(Signed) J. C. Roberts, M. D.

(Address) Pollock, Mo.

RECEIVED

District Health Officer No. 10

District File Number 12-39-2113

Date Filed DEC 7 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. 132, 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.