

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
STANDARD CERTIFICATE OF DEATH

16434

Registration District No. 929 Primary Registration District No. 6285 State File No. _____ Registrar's No. 7

1. PLACE OF DEATH:
 (a) County Wright - Union Twp
 (b) City or town Grace Springs
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution _____ (Specify whether _____)

2. USUAL RESIDENCE OF DECEASED:
 (a) State Mo. (b) County Wright
 (c) City or town Grace Springs
 (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.

In this community _____ (Specify whether _____)
 years, months or days) 5.5
 3. (a) PRINT FULL NAME JAMES BANNING
 3. (b) If veteran _____ name war _____ 3. (c) Social Security No. _____

4. Sex M 5. Color or race W
 6. (a) Single, widowed, married, divorced Widowed
 6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
 7. Birth date of deceased Nov 4 1890
 (Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>89</u>	<u>3</u>	<u>10</u>	_____ hr. _____ min.

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

10. Usual occupation Farmer

11. Industry or business Farmer

MOTHER FATHER
 12. Name Dr Banning
 13. Birthplace Mo (City, town, or county) (State or foreign country)
 14. Maiden name Mary Howard
 15. Birthplace Mo (City, town, or county) (State or foreign country)

16. (a) Informant's own signature Devery Corneer

(b) Address Willmerville Mo

17. (a) Burial (b) Date thereof April 19 1940
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation O. Bell

18. (a) Signature of funeral director R. M. Garner

(b) Address Grace Springs Mo

19. (a) 4-19-40 (b) R. M. Garner
 (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 19 year 1940 hour 4:10 minute 0 M.

21. I hereby certify that I attended the deceased from April 19, 1940 to April 19, 1940 that I last saw him alive on April 19, 1940 and that death occurred on the date and hour stated above.

Immediate cause of death Solar Burn Duration _____

Due to _____
 Due to _____

Other conditions _____ (include pregnancy within 3 months of death)

PHYSICIAN
 Major findings: _____
 Of operations _____
 Of autopsy _____
 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? 570
 While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature J. H. Roberts (M. D. or other) _____

Address Grace Springs Date signed _____

RECEIVED

District Health Officer No. 6,

District File Number 540-1327

Date Filed MAY 14 1940

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.