

FILED FEB 18 1941

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

4532

Do not use this space.

1. PLACE OF DEATH

(a) County Scott Registration District No. 820
(b) Township Sylvania Primary Registration District No. 6069
(c) City _____ (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. Oran 1 mo 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 m 4. COLOR OR RACE col. 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (*write the word*) Married
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Apr 29 '38
7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
2 9 1

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) Oran mo

FATHER 13. NAME Herbert Banke
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Vernon ark

MOTHER 15. MAIDEN NAME Mattie Shepherd
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Wabaska ark

17. INFORMANT (ADDRESS) Herbert Banks Oran mo

18. BURIAL, CREMATION, OR REMOVAL PLACE Mc Mullin Cem. DATE 1-31 1941

19. FUNERAL DIRECTOR (NAME) (ADDRESS) W. S. Schman

20. FILED 2/5 1941 W. S. Schman Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 1/30 1941

22. I HEREBY CERTIFY, That I attended deceased from 1/26 1941 to 1/30 1941
I last saw him alive on 1/26 1941 Death is said to have occurred on the date stated above, at 8 p. m.
The principal cause of death and related causes of importance were as follows:

Date of onset 1/29/41
Streptococcus
son throat (?)
Other contributory causes of importance: Gonorrhea 1/25/41

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? No.
If so, specify _____
(Signed) J. A. Oram M. D.
(Address) Oran mo

RECEIVED

District Health Officer No. 2,

District File Number 241-170

Date Filed 2/6/56

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.