

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. _____

FILED MAY 15 1942

Registration District No. 87

Primary Registration District No. 6162

Registrar's No. 27

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

1. PLACE OF DEATH:

(a) County Vernon

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

(c) Name of hospital or institution: N. W. of Nevada
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 46 (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Vernon ¹⁰⁸

(c) City or town Nevada, N. W. ⁵
(If outside city or town limits, write "RURAL")

(d) Street No. N. West of Nevada ^U
(If rural, give location)

(e) Citizen of foreign country? no (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Stella E. Banks

3. (b) If veteran, name war no

3. (c) Social Security No. no

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 13
year 1942 hour _____ minute 6:45 A.M.

4. Sex Female 5. Color or race white

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

6. (b) Name of husband or wife A. J. Banks

6. (c) Age of husband or wife if alive 66 years

7. Birth date of deceased Feb-4, 1878
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from Nov 11, 1941 to April 13, 1942
that I last saw h. e. r. alive on 4-11 and that death occurred on the date and hour stated above.

8. AGE:	Years	Months	Days	If less than one day
	<u>64</u>	<u>2</u>	<u>9</u>	hr. _____ min. _____

Immediate cause of death: Chronic interstitial nephritis

Due to arterio-sclerosis & Chronic Myocarditis

Due to Chronic healed valvular disease & Rheumatism

Other conditions none
(Include pregnancy within 3 months of death)

Duration
<u>2-3 yrs</u>
<u>11 yrs</u>
<u>25 yrs</u>

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

10. Usual occupation House wife

Major findings: none

Of operations none

Of autopsy none

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

11. Industry or business _____

12. Name Adam M. Roberts

13. Birthplace Unknown Indiana
(City, town, or county) (State or foreign country)

14. Maiden name Katchell

15. Birthplace Unknown Indiana
(City, town, or county) (State or foreign country)

16. (a) Informant A. J. Banks

(b) Address Nevada, Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: 4/15/42
(Month) (Day) (Year)

(c) Place: burial or cremation Allaway

18. (a) Signature of funeral director Marsh E. King

(b) Address Nevada, Mo.

19. (a) 4-18-42 (Date received local registrar) (b) Geney Stephens (Registrar's Signature)

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? _____

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature [Signature] (M. D. or other) _____
Address Nevada, Mo. Date signed 4-13-42

RECEIVED

District Health Officer No. 7,

District File Number 6-42-502

Date Filed 5-13-42

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

Marsh E. Schuyler

Licensed Embalmer No.

2656

P. O. Address

Nevada, Mo

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, fact should be so stated above.