

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 15160
Registrar's No. _____

FILED MAY 8 1944
Registration District No. _____

Primary Registration District No. 3041

1. PLACE OF DEATH:

(a) County Macou

(b) City or town Macou
(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 years, months or days)

In this community _____ (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Macou

(c) City or town Macou
(If outside city or town limits, write "RURAL")

(d) Street No. _____ (If rural, give location)

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

3. (a) PRINT FULL NAME Stella B Banta

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Female 5. Color or race White

6. (a) Single, widow married Married
divorced _____

6. (b) Name of husband or wife W. W. Banta

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

7. Birth date of deceased June 26 1873
(Month) (Day) (Year)

8. AGE: Years 70 Months 10 Days 4
If less than one day _____ hr. _____ min.

9. Birthplace Gran Co Illinois
(City, town, or county) (State or foreign country)

10. Usual occupation House wife

11. Industry or business _____

MOTHER FATHER { 12. Name Madison Voyles

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

14. Maiden name Hansy Mayberry

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

16. (a) Informant W. W. Banta

(b) Address Macou Mo

17. (a) Burial (b) Date thereof May 2 44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Cherry Box Mo

18. (a) Signature of funeral director Adrian Skum

(b) Address Macou Mo

19. (a) _____ (b) _____
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 30
year 1944 hour 10:30 minute a M.

21. I hereby certify that I attended the deceased from _____
to _____
that I last saw her alive on April 17
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral arteriosclerosis Duration 3 yrs.

Due to Generalized arteriosclerosis 8 yrs.

Due to _____

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

Major findings: _____

Of operations _____

Of autopsy _____

PHYSICIAN _____
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? _____

While at work? _____ (Specify type of place)

(e) Means of injury _____

23. Signatur J. J. Turner (M. D. or other)

Address Macou Mo Date signed 5-3-44

RECEIVED

District Health Officer No. 19

District File Number 5-44-872

Date Filed MAY 5 1944

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.....

Corland Mason

Licensed Embalmer No. 3414

P. O. Address

Mason

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. may

Registration District No. 200

Primary Registration District No. 3041

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Macan
(b) City or town Macan
(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
In this community 30-40 yrs years, months or days)

3. (a) PRINT FULL NAME Stella B. Banta

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex F 5. Color or race w 6. (a) Single, widowed, married, divorced _____

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased June 26 1914
(Month) (Day) (Year)

8. AGE: Years 20 Months 10 Days 26 If less than one day _____ min.

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

10. Usual occupation _____

11. Industry or business _____

12. Name _____

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

14. Maiden name _____

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

16. (a) Informant _____

(b) Address _____

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

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) 7/4/44 (b) Stella B. Banta
(Date received local registrar) (Registrar's signature)

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June 20
year 1944 hour _____ minute _____ M.

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

Duration _____

Due to _____

Due to _____

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

Major findings:
Of operations _____

Of autopsy _____

PHYSICIAN

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)

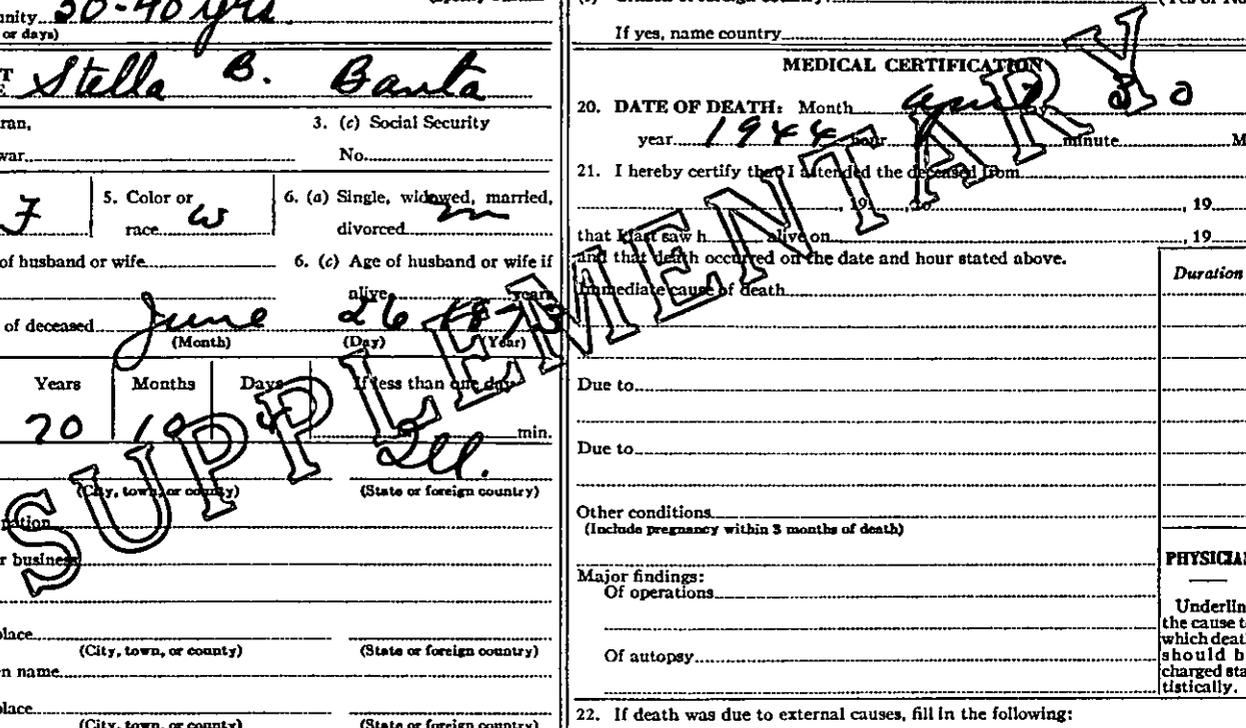
(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place)

(c) Means of injury _____

23. Signature _____ (M. D. or other) _____

Address _____ Date signed _____



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