

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____

FILED JUN 6 1944

Registration District No. _____

Primary Registration District No. 4248

Registrar's No. 9

1. PLACE OF DEATH:

(a) County Monroe
(b) City or town Wellsville Mo
(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 _____ years, months or days

3. (a) PRINT FULL NAME George Washington Bankhead

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

4. Sex Male 5. Color 2 Col 6. (a) Single, widowed, married, divorced _____

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

7. Birth date of deceased Feb - 22 - 1866
(Month) (Day) (Year)

8. AGE: Years 76 Months 2 Days 3 If less than one day _____ hr. _____ min.

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

10. Usual occupation Farmer

11. Industry or business Farming

12. Name George W Bankhead

13. Birthplace Wike Co Mo (City, town, or county) (State or foreign country)

14. Maiden name Wear

15. Birthplace Wike Co Mo (City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Helmae Bankhead

(b) Address Wellsville Mo

17. (a) Buried (b) Date thereof May 7 - 1944
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Wellsville Mo

18. (a) Signature of funeral director T. B. Keller

(b) Address Wellsville Mo

19. (a) May 8 - 1944 (b) Mrs. Virginia Foster
(Date received local registrar) (Registrar's Signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Monroe
(c) City or town Wellsville Mo
(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 5 day May
year 1944 hour 7 minute 10 P M.

21. I hereby certify that I attended the deceased from Feb 5 1944
that I last saw him alive on May 5 1944
and that death occurred on the date and hour stated above.

Immediate cause of death _____

Congenital heart failure

Due to acute endocarditis

Due to chronic endocarditis

Due to apoplexy of left brain

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings: _____

Of operations _____

Of autopsy _____

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 2

Signature Wallis H. Walls (M. D. or other) Do.

Address Wellsville Date signed 5/10/44

RECEIVED

District Health Officer No. 9,

District File Number _____

Date Filed 6-5-44

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 Ref.

_____, Registered Apprentice No. _____
working under my personal supervision.

Signed F.B. Keller

Licensed Embalmer No. 1588

P. O. Address Keller 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.