

No. 2
5-42
5-17-39

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 28355

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

FILED SEP 13 1944
Registration District No. 238

Primary Registration District No. 4355

Registrar's No. 37

1. PLACE OF DEATH:

(a) County NEW MADRID

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

(c) Name of hospital or institution: NO 1
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution NO
AT HOME (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County NEW MADRID

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

(d) Street No. 0
(If rural, give location)

(e) Citizen of foreign country? 0 (Yes or No)
If yes, name country 0

3. (a) PRINT FULL NAME ALEX DAVID BANKS

3. (b) If veteran, name war NO

3. (c) Social Security No. NO

4. Sex M 5. Color or race Black

6. (a) Single, widowed, married, divorced 0

6. (b) Name of husband or wife 0

6. (c) Age of husband or wife if alive 4 years

7. Birth date of deceased April 4 - 1944
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day

4 17 hr. min.

9. Birthplace NEW MADRID, MO
(City, town, or county) (State or foreign country)

10. Usual occupation CHILD

11. Industry or business

12. Name ARTHER LEE BANKS

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

14. Maiden name VIRGINIA MAE GRANT

15. Birthplace NEW MADRID, MO
(City, town, or county) (State or foreign country)

16. (a) Informant BERTRUDE BROWN

(b) Address NEW MADRID, MO

17. (a) BURIAL (b) Date thereof 8-22-44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation FANNIE POWELL FRIENDS

18. (a) Signature of funeral director NEW MADRID, MO

(b) Address NEW MADRID, MO

19. (a) 8-25-44 (b) Helen Louise Jones
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 21
year 1944 hour 10:30 minute 0 P.M.

21. I hereby certify that I attended the deceased from 0 1944 to 0 1944
that I last saw 0 alive on 0 and that death occurred on the date and hour stated above.

Immediate cause of death Pneumonia Duration 0

Due to.....

Due to.....

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

Major findings:
Of operations.....

Of autopsy.....

**ADDITIONAL
SUPPLEMENTARY
INFORMATION
REQUESTED**

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?
(Specify type of place)

While at work? (e) Means of injury.....

23. Signature Leo Hedy with Deputy Coroner
(M.D. or other)

*Address New Madrid, Mo Date signed 8/22-44

RECEIVED

District Health Office No. 2, D

District File Number 944-1250

Date Filed 9-12-44

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

Signed *W. Embalmer*.....

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, fact should be so stated above.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. Sept.
Registrar's No. _____

Registration District No. _____ Primary Registration District No. _____

1. PLACE OF DEATH:

(a) County New Madrid
 (b) City or town New Madrid
 (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 Alex H. Banks
 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 S
 6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased April 4 (Month) (Day) (Year)

8. AGE: Years _____ Months _____ Days _____ If less than one day, _____ min.

9. Birthplace _____ (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 _____ (Month) (Day) (Year)
 (Burial, cremation, or removal) (Place: burial or cremation)

18. (a) Signature of funeral director _____ (b) Address _____

19. (a) _____ (b) _____ (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 Aug year 1944 hour _____ minute _____ M.
 21. I hereby certify that I attended the deceased from _____ 19 _____
 that I last saw him _____ alive on _____ 19 _____
 and that death occurred on the date and hour stated above.
 Immediate cause of death _____

Pneumonia & Latex
 Due to _____
 Due to _____
 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 _____

23. Signature _____ (M. D. or other) _____
 Address _____ Date signed _____

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

MOTHER FATHER

SUPPLEMENTARY INFORMATION REQUESTED

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

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