

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____

FILED SEP 12 1944

Registration District No. _____

Primary Registration District No. 5953

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Pike
(b) City or town Rural (Buffalo Township)
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: None
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 90 (Specify whether years, months or days)
In this community 90

3. (a) PRINT FULL NAME

James Banks

3. (b) If veteran, name war 90

3. (c) Social Security No. 494-10-7058

4. Sex Male 5. Color or race Col 6. (a) Single, widowed, married, divorced married
6. (b) Name of husband or wife Mollie Banks 6. (c) Age of husband or wife if alive 43 years
7. Birth date of deceased (Month) 10 (Day) 12 (Year) 1899

8. AGE: Years 44 Months 10 Days 9 If less than one day hr. _____ min. _____

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

10. Usual occupation Operator

11. Industry or business

12. Name Hushell Banks
13. Birthplace Mississippi (City, town, or county) (State or foreign country)
14. Maiden name Minnie Bryson
15. Birthplace Forrist (City, town, or county) (State or foreign country)

16. (a) Informant Mollie Banks

(b) Address 1832 Papin St. Louis

17. (a) Buried (b) Date thereof 8-21-44 (Month) (Day) (Year)

(c) Place: burial or cremation Washington Park Cemetery

18. (a) Signature of funeral director Hus Lowe

(b) Address 2904 Chouteau Ave

19. (a) Aug 25-44 (b) St. Louis (Date registered local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Louis
(c) City or town St. Louis (If outside city or town limits, write "RURAL")
(d) Street No. 1832 Papin St (If rural, give location)
(e) Citizen of foreign country? 90 (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 23 year 1944 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ 19____ to _____ 19____;

that I last saw him alive on _____ 19____ and that death occurred on the date and hour stated above.

Immediate cause of death from loss of blood caused by accidental gunshot wound in calf of his right leg

Due to _____

Other conditions (Include pregnancy within 3 months of death) 184

Major findings:

Of operations 37
Of autopsy _____

Duration

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) Accident 187

(b) Date of occurrence Aug 23-44

(c) Where did injury occur? (Rural) near Louisiana Pike Mo. (City or town) (County) (State)

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

While at work? 90 (Specify type of place) (e) Means of injury gun shot

23. Signature W. Smith (Signature of physician)

Address Louisiana, Mo Date signed 8/24/44

(Licensed Embalmer's Statement on Reverse Side)

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

SEP 15 1944

JUL 23 1945

RECEIVED
District Health Officer No. 10
District File Number 9-44-1572
Date Filed SEP 12 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 me
_____, Registered Apprentice No. _____
working under my personal supervision.

Signed

Clark Young

Licensed Embalmer No.

P. O. Address

3371
St. Louis

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.