

S. No. 2  
OM-2-43  
v. 5-17-39  
I X35697

FILED JUN 29 1945

Primary Registration District No. 1002

Registrar's No. 2549

8938

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

1. PLACE OF DEATH:

(a) County Jackson

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

(c) Name of hospital or institution: Gen. Hosp. #2  
(If not in hospital or institution, write street number and location)

(d) Length of stay: In hospital or institution 12 Yrs.  
(Specify whether years, months or days)

3. (a) PRINT FULL NAME ERNEST BANKS

3. (b) If veteran, name war NO

3. (c) Social Security No. UNKNOWN

4. Sex Male

5. Color or race Negro

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

6. (b) Name of husband or wife \_\_\_\_\_

6. (c) Age of husband or wife if alive 1880 years

7. Birth date of deceased \_\_\_\_\_  
(Month) (Day) (Year)

8. AGE: Years 65 Months \_\_\_\_\_ Days \_\_\_\_\_  
If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

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

10. Usual occupation Laborer

11. Industry or business \_\_\_\_\_

MOTHER FATHER { 12. Name Andrew Banks

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

14. Maiden name Charlotte Smith

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

16. (a) Informant Record Clerk

(b) Address Gen. Hosp. #2

17. (a) Burial  
(Burial, cremation, or removal)

(b) Date thereof 6-16-45  
(Month) (Day) (Year)

(c) Place: burial or cremation Funeral Home

18. (a) Signature of funeral director [Signature]

(b) Address [Address]

19. (a) 6-15-45  
(Date received local registrar)

(b) [Signature]  
(Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson

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

(d) Street No. 1725 Forest  
(If rural, give location)

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 21  
year 1945 hour 12:35 minute P M.

21. I hereby certify that I attended the deceased from May 7 1945 to May 21 1945  
that I last saw him alive on May 21 1945  
and that death occurred on the date and hour stated above.

Immediate cause of death Congestive Failure  
Arteriosclerotic Heart Disease

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions 93d  
(Include pregnancy within 3 months of death)

Major findings: 93d  
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? \_\_\_\_\_

23. Signature [Signature]  
(Specify type of injury) (M. D. or other)

Address Gen. Hosp. #2 - 600 E. 22

Date signed 6-22-45

Duration \_\_\_\_\_

PHYSICIAN \_\_\_\_\_

Underline the cause to which death should be charged statistically.

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.....

*not Embalmed*....., Registered Apprentice No.....  
working under my personal supervision.

Signed *Wm A. Schuyler*.....

Licensed Embalmer No. *3089*.....

P. O. Address *ITC 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.**