S. No. 2
0M—2-43
v. 5-17-39
I X35607

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED AUG 13 1945

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 22803

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 3272

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: General Hospital 0
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 6-26-45 - 7-24-45 (Specify whether years, months or days)

In this community Do not know

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson 4k

(c) City or town Kansas City 3
(If outside city or town limits, write "RURAL")

(d) Street No. 613 Main 8
(If rural, give location) 0

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME William E. Banks

3. (b) If veteran, name war Do not know

3. (c) Social Security No. Do not know

4. Sex Male 0

5. Color or race White

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

6. (b) Name of husband or wife Do not know

6. (c) Age of husband or wife if alive Do not know years

7. Birth date of deceased January 30, 1892 (Month) (Day) (Year)

8. AGE: Years 53 Months 5 Days 24 If less than one day hr. min.

9. Birthplace Do not know (City, town, or county) 9 (State or foreign country)

10. Usual occupation

11. Industry or business

FATHER
12. Name Do
13. Birthplace Not (City, town, or county) 9 (State or foreign country)

MOTHER
14. Maiden name
15. Birthplace I know (City, town, or county) 9 (State or foreign country)

16. (a) Informant Funeral Hospital

(b) Address K. C. Mo

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/9/45 (Month) (Day) (Year)

(c) Place: burial or cremation Mt. Cabrini K. C. Mo.

18. (a) Signature of funeral director Pasquantino

(b) Address K. C. Mo.

19. (a) 8-4-45 (Date received local registrar) (b) Geraldine Holmes (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 24 year 1945 hour 8 minute 20 P.M.

21. I hereby certify that I attended the deceased from June 26, 1945 to July 24, 1945 that I last saw him alive on July 24, 1945 and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Cirrhosis of liver	
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death) 1 24 hr	

Major findings:
Of operations
Of autopsy None

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 0

23. Signature Clark W. Seely M.D. 8-3-45 (M. D. or other) (Date signed)

Address Med. Dir. K.C. General Hospital

(Licensed Embalmer's Statement on Reverse Side)

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 Frances Walton

Licensed Embalmer No. 2744

P. O. Address Ka. C. 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.