

FILED AUG 22 1945 STANDARD CERTIFICATE OF DEATH

State File No. 1

Registration District No. 381

Primary Registration District No. 4515

Registrar's No.

1. PLACE OF DEATH:

(a) County Sullivan
(b) City or town Milan
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Simpson Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 8 hours
(Specify whether years, months or days)
In this community Most of life

3. (a) PRINT FULL NAME

ROSS H. BANKUS

3. (b) If veteran,

name war ✓

3. (c) Social Security

No. ✓

4. Sex M (1) 5. Color or race W
6. (a) Single, widowed, married, divorced m
6. (b) Name of husband or wife MARY BANKUS
6. (c) Age of husband or wife if alive 85 years
7. Birth date of deceased Aug 23 1859
(Month) (Day) (Year)

8. AGE: Years 85 Months 10 Days 15
If less than one day hr. min.

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

10. Usual occupation Farmer

11. Industry or business

12. Name John Bankus
13. Birthplace Ohio
(City, town, or county) (State or foreign country)
14. Maiden name Elizabeth Pierce
15. Birthplace Ohio
(City, town, or county) (State or foreign country)

16. (a) Informant Glenn Albertson
(b) Address Green City, Mo.

17. (a) Burial (b) Date thereof 7 10 1945
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Hawkege Cem.

18. (a) Signature of funeral director Glenn E. Kent & Son
(b) Address Green City, Mo.

19. (a) July 11-45 (b) Mrs. L. D. Green
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Sullivan
(c) City or town Green City
(If outside city or town limits, write "RURAL")
(d) Street No. 0
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country No

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 8 Th
year 1945 hour 10:45 minute A.M.

21. I hereby certify that I attended the deceased from July 7, 1945, to July 8, 1945.
that I last saw him alive on July 8, 1945,
and that death occurred on the day and hour stated above.

Immediate cause of death chronic endocarditis Duration unknown

Due to acute intestinal obstruction 12 hrs.

Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy

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 Mrs. Simpson (M. D. or other)
Address Milan Date signed 7-8-45

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RECEIVED
District Health Officer No. 10
District File Number 8-45-1357
Date Filed AUG 21 1945

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 Archibald W. Wade
Licensed Embalmer No. 3037
P. O. Address Green City, 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.