

No. 2
-1/47
5-17-39

18579

FEDERAL SECURITY AGENCY
National Office of Vital Statistics
FILED JUN 13 1947

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No.

Registration District No. **318**

Primary Registration District No. **1003**

Registrar's No. **5512**

1. PLACE OF DEATH:

(a) County.....

(b) City or town **St. Louis**
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
Homer G Phillips Hospital 0
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution **19 days**
(Specify whether

In this community.....
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Wood**

(c) City or town **St. Louis**
(If outside city or town limits, write "RURAL")

(d) Street No. **2318 Walnut**
22 (If rural, give location)

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

If yes, name country.....

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

3. (b) If veteran, name war.....

3. (c) Social Security No.

4. Sex **Male** 5. Color **Col** 6. (a) Single, widowed, married, divorced **Widowed**

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

7. Birth date of deceased **Oct 6**
(Month) (Day) (Year)

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

about 66 hr. min.

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

Unknown

10. Usual occupation.....
None

11. Industry or business.....

12. Name.....
Unknown

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

Unknown

14. Maiden name.....
Unknown

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

Unknown

16. (a) Informant **Natie Mae Johnson**

(b) Address **2207 Walnut**

17. (a) **Burial** (b) Date thereof **6-4-47**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Oakdale Cemetery**

18. (a) Signature of funeral director **E. B. Rooney**

(b) Address **1221 N. Grand**

19. (a) **JUN 3 1947** (b) **J. F. Bredes**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **May** day **31**
year **1947** hour **11** minute **35 A.M.**

21. I hereby certify that I attended the deceased from **May 12**, 19**47**, to **May 31**, 19**47**, that I last saw him alive on **May 31**, 19**47**, and that death occurred on the date and hour stated above.

Immediate cause of death **Pneumonia - Hypostatic** Duration **Undet.**

Due to.....

Due to.....

Other conditions **Malnutrition**
(Include pregnancy within 3 months of death)

Major findings:
Of operations.....

Of autopsy **No**

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?..... Means of injury **A**

23. Signature **Edw B Williams** (M.D. or other) **A**
Address **2601 N Whittier** Date signed **6/2/47**

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

MOTHER FATHER

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.....

Leroy H. Pannister Registered Apprentice No. *405*
working under my personal supervision.

Signed.....

Eugene Miles

Licensed Embalmer No. *3623*

P. O. Address *1321 - N. Grand*

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.