

FILED FEB 11 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 524

49-000815

BIRTH NO. ~~55~~ REG. DIST. NO. ~~3024~~ PRIMARY REG. DIST. NO. 3011 Registrar's No. 5

1. PLACE OF DEATH a. COUNTY Carroll		2. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) a. STATE Missouri b. COUNTY Carroll	
b. CITY (If outside corporate limits, write RURAL and give town) Carrollton		c. CITY (If outside corporate limits, write RURAL and give township) Hale Missouri Rural	
c. LENGTH OF STAY (in this place)		d. STREET ADDRESS (If rural, give location) Hurricane Gap -	
d. FULL NAME OF HOSPITAL OR INSTITUTION South Side Hospital			

3. NAME OF DECEASED (Type or Print)	a. (First) JAMES	b. (Middle) FRANCIS	c. (Last) BANNAN III	4. DATE OF DEATH (Month) (Day) (Year) Jan. 18th 1949
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5. SEX M	6. COLOR OR RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) CHILD	8. DATE OF BIRTH Jan 17th, 1949	9. AGE (In years last birthday) X	IF UNDER 1 YEAR (Month) (Day) (Year) X 1	IF UNDER 24 HRS. (Hours) (Min.)
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) child	10b. KIND OF BUSINESS OR INDUSTRY XX	11. BIRTHPLACE (State or foreign country) Carrollton, Missouri	12. CITIZEN OF WHAT COUNTRY Carroll
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13a. FATHER'S NAME James F. Bannan II	13b. MOTHER'S MAIDEN NAME Beatrice (Figg) Bannan	14. NAME OF HUSBAND OR WIFE child
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME Mrs James Bannan II Hale, Mo.	ADDRESS
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Patent Paramer Ase		
	ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from **Jan 17 1949**, to **Jan 18, 1949**, that I last saw the deceased alive on **Jan 18, 1949**, and that death occurred at **1:30 P.M.**, from the causes and on the date stated above.

23a. SIGNATURE William Charles Wood	23b. ADDRESS Carrollton, Mo.	23c. DATE SIGNED 1/18/49
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE Jan. 19, 49	24c. NAME OF CEMETERY OR CREMATORY Hale Cemetery	24d. LOCATION (City, town, or county) (State) Hale, Missouri
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DATE REC'D BY LOCAL REG. 1/19/49	REGISTRAR'S SIGNATURE Mrs Herbert Calvert	25. FUNERAL DIRECTOR'S SIGNATURE Clifford W. Austin, Tina, Missouri	ADDRESS
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

RECEIVED

District Health Officer No. 8,

District File Number.....

Date Filed 2-10-49

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.....

..... Student Embalmer No.

working under my personal supervision.

Signed.....

Clifford W. Austin

Licensed Embalmer No. #233

Signed.....
Student Embalmer

P. O. Address Tina, Missouri.

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.