

FILED NOV 22 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

36225

State File No.

BIRTH NO. _____ REG. DIST. NO. 10 PRIMARY REG. DIST. NO. 4020 Registrar's No. 192

1. PLACE OF DEATH a. COUNTY <u>Audrain</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Audrain</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Martinsburg</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Martinsburg</u>	
c. LENGTH OF STAY (in this place) <u>LIFE</u>		d. STREET ADDRESS (If rural, give location) _____	
d. FULL NAME OF HOSPITAL OR INSTITUTION _____			

3. NAME OF DECEASED (Type or Print)			4. DATE OF DEATH (Month) (Day) (Year)		
a. (First) <u>MARY</u>	b. (Middle) <u>IDA</u>	c. (Last) <u>BANKS</u>	<u>November 13, 1949</u>		

5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>Aug. 29, 1872</u>	9. AGE (In years last birthday) <u>77</u>	IF UNDER 1 YEAR Months <u>2</u> Days <u>14</u>	IF UNDER 2 HRS. Hours <u></u> Min. <u></u>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	10b. KIND OF BUSINESS OR INDUSTRY _____	11. BIRTHPLACE (State or foreign country) <u>Curryville, Mo</u>	12. CITIZEN OF WHAT COUNTRY? <u>AMERICA</u>
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13a. FATHER'S NAME <u>Silas Kelly</u>	13b. MOTHER'S MAIDEN NAME <u>MARY JANE Jacobs</u>	14. NAME OF HUSBAND (or name) <u>WILLIAM WALTER Banks</u>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, or (unknown)) (If yes, give war or dates of service) <u>No</u>	16. SOCIAL SECURITY NO. _____	17. INFORMANT'S SIGNATURE OR NAME <u>William Walter Banks</u>	ADDRESS <u>Martinsburg, Mo</u>
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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 <u>2 WK.</u> <u>5 yrs.</u> <u>7220</u>
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Acute Endocarditis</u>		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Chronic Arthritis</u> 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 checked="" 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) _____
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? _____

22. I hereby certify that I attended the deceased from Nov. 10, 1949, to Nov 12, 1949, that I last saw the deceased alive on Nov 12, 1949, and that death occurred at 11A m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <u>W. P. Paige D.D.</u>	23b. ADDRESS <u>Ladonia Mo.</u>	23c. DATE SIGNED <u>Nov. 14, 1949</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>November 16, 1949</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Willsville Cemetery</u>	24d. LOCATION (City, town, or county) (State) <u>Willsville, Missouri</u>
DATE REC'D BY LOCAL REG. <u>Nov. 16, 1949</u>	REGISTRAR'S SIGNATURE <u>Blanche Neely</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>Kuhre Funeral Home</u> ADDRESS <u>Willsville, Mo.</u>	

(Licensed Embalmer's Statement on Reverse Side)

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

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RECEIVED NOV 21 1949
District Health Officer No. 10
Certificate Number 11-49-7936
NOV 21 1949
Date Filed

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.

Student _____
Student Embalmer

Signed E. Boone Schlanker

Licensed Embalmer No. 4136

P. O. Address Montgomery City, Md.

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.