

FILED JUN 10 1955

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **16446**

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1009** Registrar's No. **4594**

1. PLACE OF DEATH a. COUNTY _____		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). -a. STATE <b>MO</b> b. COUNTY _____	
b. CITY (If outside corporate limits, write RURAL and give town) <b>ST. LOUIS, MISSOURI</b>	c. LENGTH OF STAY (in this place) _____	c. CITY OR TOWN <b>St Louis</b>	d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>BARNES HOSPITAL</b>		e. STREET ADDRESS (If rural, give location) <b>1826 N. Gooden</b>	

3. NAME OF DECEASED (Type or Print) a. (First) <b>MATTIE</b>	b. (Middle) <b>(NMT)</b>	c. (Last) <b>BANKS</b>	4. DATE OF DEATH (Month) (Day) (Year) <b>May 23, 1955</b>
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5. SEX <b>F</b>	6. COLOR OR RACE <b>NEGRO</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>MARRIED</b>	8. DATE OF BIRTH <b>Sept 18 1905</b>	9. AGE (in years last birthday) <b>49</b>	IF UNDER 1 YEAR Months _____ Days _____	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) <b>HOUSEWORK</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>AT HOME</b>	11. BIRTHPLACE (City and State or Foreign Country) <b>Mississippi</b>	12. CITIZEN OF WHAT COUNTRY? _____
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13a. FATHER'S NAME <b>Shelton Hallie</b>	13b. MOTHER'S M maiden NAME <b>Coroline Toone</b>	14. NAME OF HUSBAND OR WIFE <b>Henry Banks</b>
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) _____	16. SOCIAL SECURITY NO. _____	17. INFORMANT'S SIGNATURE OR NAME <b>M. Hallie</b> ADDRESS <b>4516 Decatur</b>
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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, asthenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Uremia</b>		INTERNAL BETWEEN ONSET AND DEATH
	ANTECEDENT CAUSES DUE TO (b) <b>Chronic Glomerulonephritis</b> Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.  DUE TO (c) _____		5-6 yrs.
	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 checked="" 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) (m.) _____	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? <b>592x</b>
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22. I hereby certify that I attended the deceased from **5-5**, 19**55**, to **5-23**, 19**55**, that I last saw the deceased alive on **5-23**, 19**55**, and that death occurred at **8:10 P m.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <b>C. Vermillion, M.D.</b>	23b. ADDRESS <b>BARNES HOSPITAL</b>	23c. DATE SIGNED <b>5-24-55</b>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	24b. DATE <b>May 28</b>	24c. NAME OF CEMETERY OR CREMATORY <b>Washington Park</b>	24d. LOCATION (City, town, or county) (State) <b>9900 N. Ashbridge (State)</b>
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DATE REC'D BY LOCAL REG. <b>MAY 25 1955</b>	REGISTRAR'S SIGNATURE <b>Carl Smith</b>	25. FUNERAL DIRECTOR'S SIGNATURE <b>Burk Martway</b> ADDRESS <b>3506 Franklin</b>
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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..... Signature of Student Embalmer

Signed..... *John J. Vandell*

Licensed Embalmer No. *42*

P. O. Address *Chicago*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting. If this body is not embalmed, fact should be so stated above.