

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

20366

STATE FILE NUMBER

FILED JUL 9 1956

Registration District No. 144 Primary Registration District No. 4234 Registrar's No. 60

1. PLACE OF DEATH a. COUNTY <u>IRON</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY <u>MADISON</u>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>TRANTON</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>FREDERICKTOWN MO</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>ST MARY'S</u>		Length of stay in lb <u>5 DAYS</u>	d. STREET ADDRESS (If outside, give location) <input checked="" type="checkbox"/> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <u>ROBERT</u> Middle <u>LEE</u> Last <u>BANES JR.</u>			4. DATE OF DEATH Month <u>JUNE</u> Day <u>12</u> Year <u>1956</u>		
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAR. 24 1903</u>	9. AGE (In years last birthday) <u>53</u>	IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>BOOKKEEPER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>BOOKKEEPING</u>		11. BIRTHPLACE (City and state or country) <u>ST. FRANCIS. MO.</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>ROBERT BANES SR.</u>			14. MOTHER'S MAIDEN NAME <u>CLARA E SMITH.</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>509-09-1986</u>	17. INFORMANT <u>ROBERT BANES III TUSLA OKLA</u> Address <u>OKLA</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Terminal bronchial pneumonia</u>					INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Primary Carcinoma left lung (unoperable)</u>					<u>?</u>
DUE TO (c) _____					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (n) <u>162x</u>					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Hour _____ a. m. _____ p. m. _____	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				
20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION		COUNTY	STATE	
21. I attended the deceased from <u>6-7-56</u> to <u>6-12-56</u> and last saw <del>him</del> <u>her</u> alive on <u>6-12-56</u> Death occurred at <u>6:15 P.</u> m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <u>R. E. Farland, M.D.</u>			22b. ADDRESS <u>Tranton, mo</u>		22c. DATE SIGNED <u>6/18/56</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>6-15-56</u>	23c. NAME OF CEMETERY OR CREMATORY <u>IOOF</u>	23d. LOCATION (City, town, or county) (State) <u>FREDERICKTOWN MO</u>		
24. GENERAL DIRECTOR ADDRESS <u>W. J. Adams, Fredericktown, Mo</u>		25. DATE RECD. BY LOCAL REG. <u>6-23-56</u>	26. REGISTRAR'S SIGNATURE <u>Mrs Avis Jones</u>		

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

APR 28 1957

APR 27 1957

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STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was  
by me, or by ....., Student Embalmer No.....  
working under my personal supervision..

Student.....  
Signature of Student Embalmer

Signed *Raymond Wilson*.....

Licensed Embalmer No. *44*

P. O. Address *Frederic*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING.  
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.