

Health,
& Welfare
Public
Service

300
1-56

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

39594

STATE FILE NUMBER

FILED NOV 25 1957

Registration District No. 71 Primary Registration District No. 3012 Registrar's No. 104

1. PLACE OF DEATH a. COUNTY <u>CLAY</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY <u>CLAY</u>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>EXCELSIOR SPRINGS</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>EXCELSIOR SPRINGS</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>117 SARAZOGA</u>			Length of stay in 1b	d. STREET ADDRESS <u>117 SARAZOGA</u>			(If outside, give location) <u>Home</u> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>WILLIAM CRISLEY BANNING</u>				4. DATE OF DEATH Month Day Year <u>OCT. 31 1957</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>DEC 21, 1886</u>	9. AGE (In years last birthday) <u>70</u>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED ROCK MASON</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>CONSTRUCTION</u>		11. BIRTHPLACE (City and state or country) <u>CHARIZON COUNTY, MO</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>LOUIS BANNING</u>				14. MOTHER'S MAIDEN NAME <u>SARAH ANN RODGERS</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>MRS OMA BANNING, EX. SPRINGS, MO</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>Bronchogenic Ca. bilateral</u> <u>Primary on Rt.</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							INTERVAL BETWEEN ONSET AND DEATH <u>9 mo</u>
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>Aug 1951</u> to <u>Oct 31 1957</u> and last saw ^{her} him alive on <u>Oct 31, 1957</u> Death occurred at <u>9:10 a.m.</u> on the date stated above; and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <u>George E. Sanders M.D.</u>				22b. ADDRESS <u>Excelsior Springs, Mo</u>		22c. DATE SIGNED <u>11-1-57</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE <u>11-2-57</u>	23c. NAME OF CEMETERY OR CREMATORY <u>CROWN HILL</u>		23d. LOCATION (City, town, or county) (State) <u>EXCELSIOR SPRINGS, MO</u>		
24. FUNERAL DIRECTOR'S NAME <u>Prichard Funeral Home, Inc.</u> <u>Excelsior Springs, Missouri</u>				25. DATE RECD. BY LOCAL REG. <u>11-16-57</u>		26. REGISTRAR'S SIGNATURE <u>Caroline Kuntz</u>	

(Licensed Embalmer's Statement on Reverse Side)

62-0



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 *Luella Jarman*.....

Licensed Embalmer No. *45*

Excelsior Springs
P. O. Address.....

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.