

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

7149-58

58-009797

STATE FILE NUMBER

FILED MAR 31 1958

1201

936

Registration District No. 149

Primary Registration District No. 1002

Registrar's No.

300  
-57

1. PLACE OF DEATH a. COUNTY JACKSON		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURI b. COUNTY JACKSON	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN KANSAS CITY		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 3007 E. 19th St.		Length of stay in b 3 months	d. STREET ADDRESS (If outside, give location) 3007 E. 19th St. Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Middle Last KENNETH BANKS			4. DATE OF DEATH Month Day Year March 5, 1958		
---	--	--	---	--	--

5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH January 14, 1958	9. AGE (In years last birthday) 1	IF UNDER 1 YEAR Months Days 1 19	IF UNDER 24 HRS. Hours Min. 0 4
----------------	---------------------------	---	--------------------------------------	--------------------------------------	--	---------------------------------------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Child	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) Kans. City, Missouri	12. CITIZEN OF WHAT COUNTRY? USA
--	-----------------------------------	--	-------------------------------------

13a. FATHER'S NAME Joseph Banks	13b. MOTHER'S MAIDEN NAME Annie Pearl Franklin	14. NAME OF HUSBAND OR WIFE none
------------------------------------	---	-------------------------------------

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no	16. SOCIAL SECURITY NO. none	17. INFORMANT Joseph Banks 3007 E. 19th St. Father Address
---	---------------------------------	--

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Broncho-Pneumonia		INTERVAL BETWEEN ONSET AND DEATH 4 1/2
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) Hypertrophied Thyroid Gland - malnutrition		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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 Month, Day, Year a.m. p.m.	

20d. INJURY OCCURRED WHILE AT <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 \_\_\_\_\_ to \_\_\_\_\_ and last saw her alive on \_\_\_\_\_  
Death occurred at \_\_\_\_\_ m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE Deputy Coroner	22b. ADDRESS 1618 Lydia Ave	22c. DATE SIGNED 3/5/58
----------------------------------	--------------------------------	----------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 3-7-58	23c. NAME OF CEMETERY OR CREMATORY Lincoln	23d. LOCATION (City, town, or county) Kans. City, Missouri
---	---------------------	---	---

24. FUNERAL DIRECTOR Watkins Bros. Funeral Home 18th & Benton	25. DATE RECD. BY LOCAL REG. 3-6-58	26. REGISTRAR'S SIGNATURE Irene Marshall
--	--	---

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

I. M. Tillman  
All diseases in Part I must be causally related.



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 *Bruce R. Watkins* .....

Licensed Embalmer No. *4500* .....

P. O. Address *18th & Benton* .....

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.