Health, Welfare Public Service

300 -57

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

59-001192

STATE FILE NUMBER

FILED FEB 5 1959 Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 355

1. PLACE OF DEATH
a. COUNTY Jackson
b. CITY OR TOWN Kansas City — Inside Limits Yes [X] No [ ]
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location) 2939 Olive St — Length of stay in 1b 3 yrs

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Missouri b. COUNTY Jackson
c. CITY OR TOWN Kansas City — Inside Limits Yes [X] No [ ]
d. STREET ADDRESS (If outside, give location) 2939 Olive St — Reside on Farm Yes [ ] No [ ]

3. NAME OF DECEASED (Type or print): First Oscar Middle Robert Last Banks
4. DATE OF DEATH: Month I Day I6 Year I959
5. SEX male
6. COLOR OR RACE Negro
7. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]
8. DATE OF BIRTH Dec 8 I884
9. AGE (In years last birthday) 75 — IF UNDER 1 YEAR Months Days — IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) custodian
10b. KIND OF BUSINESS OR INDUSTRY Postoffice
11. BIRTHPLACE (City and state or country) St. Joseph Mo.
12. CITIZEN OF WHAT COUNTRY? U. S. A.
13a. FATHER'S NAME Gabriel Banks
13b. MOTHER'S MAIDEN NAME Nancy White
14. NAME OF HUSBAND OR WIFE Mabel Banks
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. none
17. INFORMANT Mabel Banks Address 2939 Olive St K. C. Mo.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH 2 hrs
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b) Cerebral Apoplexy — 6 wks
DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)
19. WAS AUTOPSY PERFORMED? YES [ ] NO [ ]

20a. ACCIDENT [ ] SUICIDE [ ] HOMICIDE [ ]
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. Month, Day, Year
20d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
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 12-1-58, to 12-24-58 and last saw her/him alive on 12-24-58
Death occurred at _____ m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE D. Frederick A. Treffer (Degree or title) M.D.
22b. ADDRESS 5518 Truman Rd KC Mo
22c. DATE SIGNED 1-22-59

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial
23b. DATE I-20-I959
23c. NAME OF CEMETERY OR CREMATORY Blue Ridge Lawn Cemetery
23d. LOCATION (City, town, or county) (State) Kansas City, Missouri

24. FUNERAL DIRECTOR Adkins Funeral Home ADDRESS Kansas City, Mo
25. DATE RECD. BY LOCAL REG. 1-20-59
26. REGISTRAR'S SIGNATURE Neva Minshall

(Licensed Embalmer's Statement on Reverse Side)

All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

Frederick A. Treffer

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 .....

Licensed Embalmer No. .....

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.