

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS JUN 6 1960

-60-020510

Registration District No. 310 Primary Registration District No. 3058 Registrar's No. 110

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>St. Charles</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>St. Charles</u>				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Charles</u>		Length of stay in lb <u>6 years</u>		c. CITY OR TOWN <u>St. Charles</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>821 S. Fifth Street</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>821 South Fifth St.</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Joseph</u> Middle <u>William</u> Last <u>Banker</u>				4. DATE OF DEATH Month <u>May</u> Day <u>22</u> Year <u>1960</u>				
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <u>9/12/95</u>		
9. AGE (last birthday) <u>64</u>		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		IF UNDER 24 HR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Gas Company</u>		11. BIRTHPLACE (City and state or country) <u>Flint Hill, Missouri</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>		
13a. FATHER'S NAME <u>Adolph Banker</u>		13b. MOTHER'S MAIDEN NAME <u>Kathryn McKain</u>		14. NAME OF HUSBAND OR WIFE <u>None</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>496-14-8891</u>		17. INFORMANT <u>David Banker</u>		Address <u>St. Charles, 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>EVIDENT NATURAL CAUSES</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>COPPER NOTIFIED ME 22-60</u> DUE TO (c) <u>STATEMENT J. EISENBAUM MAY 23-60</u>						INTERVAL BETWEEN ONSET AND DEATH		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)						PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		
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 <u> </u> a.m. <u> </u> p.m. <u> </u>		Month, Day, Year <u> </u>						
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 _____ 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 (Degree or title) <u>Michael Wilson, M.D., Reg.</u>				22b. ADDRESS <u>902 Kellen St. Charles</u>		22c. DATE SIGNED <u>5/23/60</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>May 24, 1960</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Linn Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Wentzville Mo.</u>		
24. FUNERAL DIRECTOR <u>Arthur C. Baue</u>		ADDRESS <u>St. Charles, Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>MAY 23-60</u>		26. REGISTRAR'S SIGNATURE <u>Michael Wilson</u>		

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

0961 8 NOV SA

JUL 13 1961

0961 8 OCT

STATEMENT BY LICENSED EMBALMER

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

Student _____
Signature of Student Embalmer

Signed David C. Paul

Licensed Embalmer No. 506

P. O. Address St. Charles

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.