IRI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

) VS DEC 21 1960 Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 11992 —60—047272 STATE FILE NUMBER

NDED

1. PLACE OF DEATH
a. COUNTY
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: St. Louis
Length of stay in 1b
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: Homer G. Phillips
Inside Limits: Yes ☐ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Missouri
b. COUNTY
c. CITY OR TOWN: St. Louis
Inside Limits: Yes ☐ No ☐
d. STREET ADDRESS (If outside, give location): 705 N. Channing
Reside on Farm: Yes ☐ No ☐

3. NAME OF DECEASED (Type or print) First: Clarence Middle: Last: Banks
4. DATE OF DEATH Month: 12 Day: 11 Year: 60
5. SEX: Male
6. COLOR OR RACE: Negro
7. Married ☒ Never Married ☐ Widowed ☐ Divorced ☐
8. DATE OF BIRTH: 4-6-1914
9. AGE (last birthday): 46
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HR: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): NA Labor
10b. KIND OF BUSINESS OR INDUSTRY: NONE
11. BIRTHPLACE (City and state or country): Mississippi
12. CITIZEN OF WHAT COUNTRY: U, S, A,
13a. FATHER'S NAME: Will Banks
13b. MOTHER'S MAIDEN NAME: LuLa
14. NAME OF HUSBAND OR WIFE: Mary C 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.: 489-07-5203
17. INFORMANT: Mary C Banks Address: 705 N. Channing

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): Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: Undet.
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b): Malignant Hypertension — Undet.
DUE TO (c): 441 X
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a): Hypertensive Cardiovascular Disease, Uremia
PART III. If deceased was female was there a pregnancy in last 90 days. ☐ Yes ☐ No ☐ Unknown
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 12-9-60, to 12-11-60 and last saw ~~her~~ him alive on 12-11-60
Death occurred at 8:50 a.m. on the date stated above, and to the best of my knowledge, from the causes stated.
22a. SIGNATURE (Degree or title): Sydney A. Mason M. D.
22b. ADDRESS: 2601 N. Whittier St.
22c. DATE SIGNED: 12-12-60
23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE: 12-17-1960
23c. NAME OF CEMETERY OR CREMATORY: Greenwood Cemetery
23d. LOCATION (City, town, or county) (State): 6571 St, Louis Ave LO
24. FUNERAL DIRECTOR: E, J, Golden ADDRESS: 3404 Delmar Blvd,
25. DATE RECD. BY LOCAL REG.: DEC 14 1960
26. REGISTRAR'S SIGNATURE: Earl Smith, M.D.

DOCUMENT

BY AFFIDAVIT OF

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_____ Signed Leroy H. Dennis

Signature of Student Embalmer

Licensed Embalmer No. 45 2

P. O. Address 4251 Wo

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