

570 MAR 9 1939

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

5357
Do not use this space.

1. PLACE OF DEATH

(a) County Jackson Registration District No. 399
(b) Township Staw Primary Registration District No. 1002
(c) City Kansas City (d) Street No. 900 Crystal St. _____
(If death occurred in Hospital or Institution, write its name instead of street and number)
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

(a) Residence, No. 900 Crystal St. (If nonresident, give city or town and State)
(Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX Male 4. COLOR OR RACE Col. 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Married
5A. IF MARRIED, WIDOWED, OR DIVORCED - HUSBAND OF (or) WIFE OF Lucy Banks
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Unknown
7. AGE YEARS 54 MONTHS _____ DAYS _____ If LESS than 1 day, _____ hrs. or _____ min.
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Consul General
9. Industry or business in which work was done, as saw mill, bank, etc. St PA
10. Date deceased last worked at this occupation (month and year) _____ 11. Total time (years) spent in this occupation _____

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 2/8 39
22. I HEREBY CERTIFY, That I attended deceased from Feb 1, 1939, to Feb 8, 1939
I last saw him alive on Feb 8, 1939. Death is said to have occurred on the date stated above, at 8:30 P.M.
The principal cause of death and related causes of importance were as follows:

Endocarditis Acute Date of onset 2/8
9/2
Other contributory causes of importance: Anemia

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ky.
13. NAME Dan Banks
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Unk.
15. MAIDEN NAME Unknown
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Unk.
17. INFORMANT (ADDRESS) Lucy Banks
900 Crystal
18. BURIAL, CREMATION, OR REMOVAL PLACE Lincoln DATE 2/13 39
19. FUNERAL DIRECTOR (NAME) (ADDRESS) Hatkins Bros
1729 Lyden
20. FILED 2-10-39 M. M. Crow, said
Local Registrar.

Name of operation none Date of _____
What test confirmed diagnosis? _____ Was there an autopsy? no
23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? _____ Date of injury _____, 19____
Where did injury occur? _____ (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.
Manner of injury _____
Nature of injury _____
24. Was disease or injury in any way related to occupation of deceased? _____
If so, specify St H Barrett M. D.
(Signed) _____ (Address) 1523 Broad St R 2 No

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S SIGNATURE
CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

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

Registered Apprentice No....., working under my personal supervision.

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 this body is not embalmed, above space should be left blank.