No. 2
4-13-40
-17-39
X23159

FILED APR 15 1941

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

11469

State File No.

Registration District No. 605 Primary Registration District No. ~~43~~ 5804 Registrar's No.

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD.

2 5 0

1. PLACE OF DEATH:
(a) County NEW-MADRID
(b) City or town PARMA
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: ✓
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution ✓ (Specify whether
In this community 1
years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County New Madrid
(c) City or town Parma 72
(If outside city or town limits, write "RURAL")
(d) Street No. 5
(If rural, give location)
(e) If foreign born, how long in U. S. A.? 0 years.

3. (a) PRINT FULL NAME TESSIE-BANKSTON
3. (b) If veteran, name war ✓
3. (c) Social Security No.
4. Sex Female
5. Color or race White
6. (a) Single, widowed, married, divorced Widowed
6. (b) Name of husband ~~or wife~~ William Bankston dead
6. (c) Age of husband or wife if alive years
7. Birth date of deceased Oct (Month) 1st (Day) 1889 (Year)

8. AGE: Years	Months	Days	If less than one day
51	5	20	hr. min.

9. Birthplace East Prairie (City, town, or county) Mo (State or foreign country)
10. Usual occupation House Keeping
11. Industry or business
FATHER
12. Name William Green
13. Birthplace Unknown (City, town, or county) 9 (State or foreign country)
MOTHER
14. Maiden name Cornelia Kelly
15. Birthplace Unknown (City, town, or county) 4 (State or foreign country)
16. (a) Informant Cornelia Yant
(b) Address Parma Mo.
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar. 22-1941 (Month) (Day) (Year)
(c) Place: burial or cremation Mt. Gilliard
18. (a) Signature of funeral director Watkins
(b) Address Parma Mo.
19. (a) 4/1/41 (Date received local registrar) (b) Dr. Geo. Husted (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 21st year 1941 hour 4:00 minute 15 A M.
21. I hereby certify that I attended the deceased from 3-16-41, 19__, to 3-21-40, 19__; that I last saw him alive on 3-20-41, 19__; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Lobar Pneumonia	3 days
Due to Following Influenza	7 days
Due to	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations	
Of autopsy	

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify)
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? 5 24 (Specify type of place)
While at work? (e) Means of injury ✓
23. Signature J. H. Gilbert (~~M.D.~~ or other) MD
Address Parma - Mo. Date signed 3-22-41

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No.
District File Number 441-41
Date Filed 4/11/41

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 wi the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.