

S. No. 2
4-8-43
5-17-39
1 X37823

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

38717/0

State File No. _____

FILED DEC 12 1944

Registration District No. 317

Primary Registration District No. 6076

Registrar's No. 2459

1. PLACE OF DEATH:

(a) County St. Louis
(b) City or town St. Louis, Mo. Jennings
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Elms Nursing Home, Jennings, Mo.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 3 years 4
(Specify whether years, months or days)
In this community 40 Years

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 016
(c) City or town St. Louis, Mo.
(If outside city or town limits, write "RURAL")
(d) Street No. 5812 Enright
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Emma Elphenia Bankes

3. (b) If veteran, name war No 3. (c) Social Security No. No

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced widowed
6. (b) Name of husband or wife Herman 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased May 22 1866
(Month) (Day) (Year)

8. AGE: Years 78 Months 7 Days 10 If less than one day hr. _____ min. _____

9. Birthplace Anna Ills ✓
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business At Home

MOYER FATHER { 12. Name Thomas Boon
13. Birthplace Unknown ✓
(City, town, or county) (State or foreign country)
14. Maiden name Unknown
15. Birthplace Unknown ✓
(City, town, or county) (State or foreign country)

16. (a) Informant Addie B. Chamberlain

(b) Address 825 N. Spanish - Cape Girardeau, Mo

17. (a) Burial (b) Date thereof 12/5/44.
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Park Lawn Cem.

18. (a) Signature of funeral director A. W. McLaughlin
(b) Address 2301 Lafayette Ave.

19. (a) DEC 6 1944 (b) E. J. McLaughlin Registrar's signature
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec. day 2nd 1944
year 1944 hour 12 m. minute _____ M. _____

21. I hereby certify that I attended the deceased from Jan 22
1942 to Dec. 2 1944
that I last saw h & r alive on Dec. 2 1944
and that death occurred on the date and hour stated above.

Immediate cause of death Chronic myocarditis Duration 5 yrs?

Due to _____
Due to 93k

Other conditions Arterio-sclerosis 10 yrs?
(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? _____

While at work? _____ (Specify type of place) (e) Means of injury 0
Signature D. Eugene Arnold (M. D. or other) M.D.
Address 1449 Mc Laran Date signed 12/5/44

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

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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.....

R. P. Cooper

Licensed Embalmer No. *3633*

P. O. Address. *2317 Lafayette*

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, fact should be so stated above.