

THE STATE BOARD OF HEALTH OF MISSOURI
 STANDARD CERTIFICATE OF DEATH

FILED JAN 20 1945 318
 Registration District No. _____

Primary Registration District No. 1003

Registrar's No. 284

1. PLACE OF DEATH:

(a) County: _____
 (b) City or town: St. Louis, Missouri
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
Homer G. Phillips Hospital
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 2 days 0
(Specify whether)
 In this community 3 months
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State: Missouri (b) County: _____
 (c) City or town: St. Louis,
(If outside city or town limits, write "RURAL")
 (d) Street No. 1524 Biddle
(If rural, give location)
 (e) Citizen of foreign country? _____ (Yes or No)
 If yes, name country: _____

3. (a) PRINT FULL NAME Floyd Banks
 3. (b) If veteran, name war: ---- 3. (c) Social Security No. _____

4. Sex: Male 5. Color or race: Negro 6. (a) Single, widowed, married, divorced: Married
 6. (b) Name of husband or wife: Penella Banks 6. (c) Age of husband or wife if alive: ? years
 7. Birth date of deceased: April 11th 1912
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>32</u>	<u>8</u>	<u>26</u>	_____ hr. _____ min.

9. Birthplace: Grace Mississippi
(City, town, or county) (State or foreign country)

10. Usual occupation: Laborer

11. Industry or business: ----

12. Name: Lee Banks
 13. Birthplace: Unavailable Mississippi
(City, town, or county) (State or foreign country)

14. Maiden name: Ida Arnold
 15. Birthplace: Greenfield Mississippi
(City, town, or county) (State or foreign country)

16. (a) Informant: Ida Banks
 (b) Address: 1524 Biddle St.

17. (a) Burial (b) Date thereof: 1-13-1945
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation: Greenwood Cemetery
 18. (a) Signature of funeral director: Charles J. Gates
 (b) Address: 4107 Finney Ave.

19. (a) JAN 10 1945 J. J. Bredich
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month January day 7,
 year 1945 hour 2 minute 50 P.A.M.
 21. I hereby certify that I attended the deceased from January
5, 1945, to January 7, 1945
 that I last saw him alive on January 7, 1945
 and that death occurred on the date and hour stated above.

Immediate cause of death: Cerebral Vascular Accident Duration: 2 days

Due to: Malignant Hypertension Unk.

Due to: _____

Other conditions: _____
(Include pregnancy within 3 months of death)

Major findings: _____
 Of operations: _____

Of autopsy: _____

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: _____

23. Signature: [Signature] (M. D. or other) _____
 Address: [Address] Date signed: 1/10/45

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

MOTHER, FATHER

25
 251
 9

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

APR 2 1945

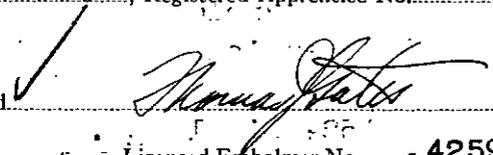
STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

Thomas J. Gates Registered Apprentice No.....

working under my personal supervision.

Signed.....



Licensed Embalmer No. 4259

P. O. Address: 4107 Finney Ave.

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.