

FILED JUL 12 1949

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 22213

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 322 PRIMARY REG. DIST. NO. 3071 Registrar's No. 44

97  
2  
1

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

|  |  |   |  |
|--|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Saline</b>   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>- a. STATE <b>Missouri</b> b. COUNTY <b>Saline</b> |  |
| b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>Slater</b> |  | c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>Slater</b>  |  |
| d. FULL NAME OF HOSPITAL OR INSTITUTION <b>309 South Emerson St.</b>                       |  | d. STREET ADDRESS (If rural, give location) <b>309 South Emerson, St.</b>   |  |

|   |  |   |  |   |  |
|---|--|---|--|---|--|
| 3. NAME OF DECEASED (Type or Print)<br>a. (First) <b>Daisy</b> b. (Middle) <b>Mae</b> c. (Last) <b>Banks</b>    |  |   | 4. DATE OF DEATH (Month) (Day) (Year)<br><b>June-27-49</b> |   |  |
| 5. SEX <b>Female</b>  |  | 6. COLOR OR RACE <b>Negro</b>                         |  | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Widow</b> |  |
| 8. DATE OF BIRTH <b>Nov. 26-94</b>  |  | 9. AGE (In years last birthday) <b>55</b>             |  | 10. IF UNDER 1 YEAR Days <b>8</b> Hours <b>1</b> Mins.              |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House Keeper</b> |  | 10b. KIND OF BUSINESS OR INDUSTRY <b>Housekeeping</b> |  | 11. BIRTHPLACE (State or foreign country) <b>New Frankford, Mo.</b> |  |
| 12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>  |  |   |  |   |  |

|  |  |   |  |   |  |
|--|--|---|--|---|--|
| 13a. FATHER'S NAME <b>Milton Jackson</b> |  | 13b. MOTHER'S MAIDEN NAME <b>Mary Jane Wilson</b> |  | 14. NAME OF HUSBAND OR WIFE <b>none</b> |  |
|--|--|---|--|---|--|

|  |  |  |  |  |  |
|--|--|--|--|--|--|
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No.</b> |  | 16. SOCIAL SECURITY NO. (If yes, give war or dates of service) |  | 17. INFORMANT'S SIGNATURE OR NAME <b>Cecil Banks Slater, Mo.</b> |  |
|  |  |  |  | ADDRESS  |  |

|   |  |   |  |  |  |                                  |  |
|---|--|---|--|--|--|----------------------------------|--|
| 18. CAUSE OF DEATH<br>Enter only one cause per line for (a), (b), and (c)<br><br>*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death. |  | MEDICAL CERTIFICATION<br>I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Coronary Occlusion</b>   |  |  |  | INTERVAL BETWEEN ONSET AND DEATH |  |
|   |  | ANTECEDENT CAUSES<br>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.<br>DUE TO (b) <b>Hypertension</b><br>DUE TO (c) <b>Mode of Life</b> |  |  |  |                                  |  |
|   |  | II. OTHER SIGNIFICANT CONDITIONS<br>Conditions contributing to the death but not related to the disease or condition causing death.   |  |  |  | <b>4201</b>                      |  |

|                        |  |                                  |  |  |  |  |  |
|------------------------|--|----------------------------------|--|--|--|--|--|
| 19a. DATE OF OPERATION |  | 19b. MAJOR FINDINGS OF OPERATION |  |  |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
|------------------------|--|----------------------------------|--|--|--|--|--|

|  |  |  |  |   |  |
|--|--|--|--|---|--|
| 21a. ACCIDENT SUICIDE HOMICIDE (Specify) <input checked="" type="checkbox"/> |  | 21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <input checked="" type="checkbox"/> |  | 21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) |  |
|--|--|--|--|---|--|

|   |  |  |  |                            |  |
|---|--|--|--|----------------------------|--|
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min) |  | 21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> |  | 21f. HOW DID INJURY OCCUR? |  |
|---|--|--|--|----------------------------|--|

22. I hereby certify that I attended the deceased from **Investigated 6-27, 1949** that I last saw the deceased alive on **1**, 19**49**, and that death occurred at **2:30 p.m.**, from the causes and on the date stated above.

|  |  |                                  |  |                                 |  |
|--|--|----------------------------------|--|---------------------------------|--|
| 23a. SIGNATURE (Degree or title) <b>C. L. Howless Coroner M.D.</b> |  | 23b. ADDRESS <b>Marshall Mo.</b> |  | 23c. DATE SIGNED <b>6-29-49</b> |  |
|--|--|----------------------------------|--|---------------------------------|--|

|   |  |                              |  |   |  |  |  |
|---|--|------------------------------|--|---|--|--|--|
| 24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b> |  | 24b. DATE <b>June 30, 49</b> |  | 24c. NAME OF CEMETERY OR CREMATORY <b>Mt. Mariah Cemetery</b> |  | 24d. LOCATION (City, town, or county) (State) <b>Slater, Mo.</b> |  |
|---|--|------------------------------|--|---|--|--|--|

|   |  |  |  |  |  |                              |  |
|---|--|--|--|--|--|------------------------------|--|
| DATE REC'D BY LOCAL REG. <b>6-30-49</b> |  | REGISTRAR'S SIGNATURE <b>Mrs. Earl C. Metz</b> |  | FUNERAL DIRECTOR'S SIGNATURE <b>Green and Sons</b> |  | ADDRESS <b>Marshall, Mo.</b> |  |
|---|--|--|--|--|--|------------------------------|--|

RECEIVED JUL 5  
District Health Officer No. 3,  
District File Number \_\_\_\_\_  
Date Filed 7-7-49

JAN 31 1951

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 \_\_\_\_\_

Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student \_\_\_\_\_  
Student Embalmer

Signed George W. Green

Licensed Embalmer No. 4220

P. O. Address Waukegan, Ill.

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.