

FILED APR 18 1957

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

12045

STATE FILE NUMBER

Registration District No. 27 Primary Registration District No. 3005 Registrar's No. 44

1. PLACE OF DEATH a. COUNTY <b>Bates</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Bates</b>						
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Butler</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <b>00700</b>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>				
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Butler Mem. Hosp.</b>			Length of stay in lb <b>12 Day</b>		d. STREET ADDRESS <b>Deer Creek Twp.</b>		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>Charles Jackson Banker</b>				4. DATE OF DEATH Month Day Year <b>March 26 1957</b>						
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>May 1 1883</b>		9. AGE (In years last birthday) <b>73</b>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <b>Minneapolis, Minn.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		IF UNDER 1 YEAR Months Days Hours Min.		
13. FATHER'S NAME <b>Brewster D. Banker</b>				14. MOTHER'S MAIDEN NAME <b>Effie Dean</b>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>495-01-7595</b>		17. INFORMANT Address <b>Mrs. Almeda A. Banker, Adrian Mo.</b>						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral ischemia, infarct</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>Cerebral ischemia</b> DUE TO (c) <b>Cerebral ischemia</b> PART II: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								INTERVAL BETWEEN ONSET AND DEATH <b>3-24-57</b> <b>3-23-57</b>		
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year										
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION		COUNTY		STATE	
21. I attended the deceased from <b>3-14-57</b> to <b>3-26-57</b> and last saw <sup>hear</sup> him alive on <b>3-23-57</b> Death occurred at <b>7:30 A.M.</b> m on the date stated above; and to the best of my knowledge, from the causes stated.										
22a. SIGNATURE (Type or type) <b>E. E. Robinson M.D.</b>				22b. ADDRESS <b>Adrian Mo.</b>				22c. DATE SIGNED <b>3-26-57</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		23b. DATE <b>3-29-57</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mound Grove Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Independance, Mo.</b>				
24. FUNERAL DIRECTOR ADDRESS <b>Six Funeral Service, Adrian Mo.</b>				25. DATE RECD. BY LOCAL REG. <b>Mar. 28-57</b>		26. REGISTRAR'S SIGNATURE <b>Randall Hervey</b>				

(Licensed Embalmer's Statement on Reverse Side)

Health,  
Welfare  
Public  
Service300  
1-56

007/0

All symptoms will be listed. All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

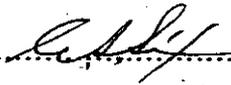
Securing the medical certificate in the specified manner is the responsibility of the medical certifier.

7-0

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.....  
Signature of Student Embalmer

Signed..... 

Licensed Embalmer No. 3650.

P. O. Address Adrian, Mo.,

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.