

URI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS JUL 5 1960

=60-022288

STATE FILE NUMBER

Registration District No. 38 Primary Registration District No. 2006 Registrar's No. 374

1. PLACE OF DEATH a. COUNTY <u>Boone</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Livingston</u>					
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Columbia</u>		Length of stay in 1b <u>4 da</u>		c. CITY OR TOWN <u>Chillicothe</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Mo. University Medical Center</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>1018 Cherry</u>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <u>Perry</u> Middle <u>LeRoy</u> Last <u>Banks</u>				4. DATE OF DEATH Month <u>June</u> Day <u>28</u> Year <u>1960</u>					
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <u>9-6-90</u>	9. AGE (last birthday) <u>69</u>	IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u>	IF UNDER 24 HR Hours <u>0</u> Min. <u>0</u>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Measurement Worker</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Caldwell Co. Mo.</u>		11. BIRTHPLACE (City and state or country) <u>U.S. of Am.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S. of Am.</u>		
13a. FATHER'S NAME <u>John Banks</u>			13b. MOTHER'S MAIDEN NAME <u>Jennie Maxion</u>			14. NAME OF HUSBAND OR WIFE <u>Jessie Banks</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>			16. SOCIAL SECURITY NO. <u>490-10-3148</u>		17. INFORMANT Address <u>Medical Record University of Mo. Medical Center</u>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:							INTERVAL BETWEEN ONSET AND DEATH		
IMMEDIATE CAUSE (a) <u>Cardiac asystole</u>							<u>0</u>		
DUE TO (b) <u>Hyperkalemia</u>							<u>18 hrs</u>		
DUE TO (c) <u>Anuria</u>							<u>5 hrs</u>		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal illness (Specify): <u>Renish postoperative hypertension, pulmonary fibrosis & emphysema, arteriosclerotic heart disease, Shock due to infection, Hypostatic bronchopneumonia.</u>							PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	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 WORK <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 <u>June 24 1960</u> to <u>June 28 1960</u> and last saw her alive on <u>June 28, 1960</u> Death occurred at <u>8:49 pm</u> m on the date stated above, and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE (Degree or title) <u>John K. Legan MD</u>				22b. ADDRESS <u>U. of Mo. med. center</u>				22c. DATE SIGNED <u>6/29/60</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		23b. DATE <u>6-29-1960</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Highland Cemetery</u>		23d. LOCATION (City, town, or county) <u>HAMILTON, MO</u>				
24. FUNERAL DIRECTOR <u>Parsons FUNERAL SERVICE</u>			ADDRESS <u>COLUMBIA MISSOURI</u>		25. DATE RECD. BY LOCAL REG. <u>June 29 1960</u>		26. REGISTRAR'S SIGNATURE <u>Mrs R E Palmer,</u>		

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by _____
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Donald I Roberts

Licensed Embalmer No. 4922
P. O. Address Columbia

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.