

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

0042753

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 317 Primary Registration District No. 500 Registrar's No. 3390

FILED OCT 19 1964

VS 300
Rev. 4/59

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20940

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90192

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

ITEM NO. SHOULD READ

USE BLACK INK OR TYPEWRITER RIBBON

1. PLACE OF DEATH a. COUNTY St. Louis			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Creve Coeur, Missouri.		Length of stay in 1b	c. CITY OR TOWN Leadwood		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. John Mercy Hospital		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 202 South Grand Avenue,		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print): Henry Edward Bannister			4. DATE OF DEATH Month October Day 6 Year 1964		
5. SEX Male	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 12/2/1911	9. AGE (last birthday) 52	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Laborer		10b. KIND OF BUSINESS OR INDUSTRY Mo. Pacific R. R.	11. BIRTHPLACE (City and state or country) Bonne Terre, Missouri.		12. CITIZEN OF WHAT COUNTRY U.S.A.
13a. FATHER'S NAME Michael Bannister		13b. MOTHER'S MAIDEN NAME Hattie Mae McKay		14. NAME OF HUSBAND OR WIFE Nil	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No Nil		16. SOCIAL SECURITY NO. None		17. INFORMANT Mrs. Louise Barron, 202 So. Grand Ave., Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) pulmonary insuff			Leadwood, Missouri. INTERVAL BETWEEN ONSET AND DEATH		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) pneumonia					
DUE TO (c) probable wartime tuberculosis					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)				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 type="checkbox"/> NO <input checked="" 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 9/27/64 , to 10/6/64 and last saw ^{her} him alive on 10/6/64 Death occurred at 8:40 P.M. m on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <i>A. D. Curran, M.D.</i> (Degree or title)		22b. ADDRESS St. Louis, Mo.		22c. DATE SIGNED 10-8-64	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 10/10/64	23c. NAME OF CEMETERY OR CREMATORY Leadwood Cemetery		23d. LOCATION (City, town, or county) Leadwood, Missouri. (State)	
24. FUNERAL DIRECTOR Boyer Funeral Home, Leadwood, Missouri. ADDRESS		25. DATE RECD. BY LOCAL REG. 10-10-64	26. REGISTRAR'S SIGNATURE <i>John B. Mumphy, M.D.</i>		

STATE OF MISSISSIPPI
DEPARTMENT OF HEALTH
DIVISION OF PUBLIC HEALTH
EMBALMERS' BOARD

6104

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 Stanley B. Simpson

Licensed Embalmer No. 4193

P. O. Address As Lovers

- 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.