WASHINGTON STATE DEPARTMENT OF HEALTH

STATE FILE NO. 23397

REG. DIST NO. M-1

CERTIFICATE OF DEATH

REGISTRAR'S NO. 1915

1. PLACE OF DEATH
a. COUNTY: Pierce
b. CITY, TOWN, OR LOCATION: Tacoma
c. LENGTH OF STAY IN 1b: 59 years
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Mt. View General Hospital
e. IS PLACE OF DEATH INSIDE CITY LIMITS? Yes [X] No [ ]

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
a. STATE: Washington b. COUNTY: Pierce
c. CITY, TOWN, OR LOCATION: Tacoma
d. STREET ADDRESS: Croft Hotel
e. IS RESIDENCE INSIDE CITY LIMITS? Yes [X] No [ ]
f. IS RESIDENCE ON A FARM? Yes [ ] No [X]

3. NAME OF DECEASED (Type or print): First: EDWIN Middle: J. Last: BANNISTER

4. DATE OF DEATH: Month, Day, Year: November 30, 1959

5. SEX: M

6. COLOR OR RACE: W

7. Married [ ] Never Married [X] Widowed [ ] Divorced [ ]

8. DATE OF BIRTH: 3-10-84

9. AGE (In years last birthday): 75
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Railroad Laborer

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Illinois

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Christian H. Bannister

14. MOTHER'S MAIDEN NAME: Jennie Townsend 180X

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: Unknown

17. INFORMANT Address: Hospital Records, Mt. View General Hosp.

MEDICAL CERTIFICATION

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 Edema: hydrohemothorax — INTERVAL BETWEEN ONSET AND DEATH: — —

Conditions, if any, which give rise to above cause (a), stating the underlying cause last.
DUE TO (b): Metastatic Carcinoma — Unknown
DUE TO (c): Hypernephroma kidney (right) — 1 Year

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? Yes [X] No [ ]

20a. ACCIDENT [ ] **SUICIDE** [ ] **HOMICIDE** [ ]

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:

DEC 2 1 1959

20d. INJURY OCCURRED While at work [ ] Not while at work [ ]

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 11-19-59, to 11-30-59 and last saw ~~him~~ alive on 11-30-59
Death occurred at 2:45 a. m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): Hospital Staff Clarence Allison, M. D. Superintendent

22b. ADDRESS: Mt. View General Hospital

22c. DATE SIGNED: 12-2-59

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b. DATE: 12/2/59

23c. NAME OF CEMETERY OR CREMATORY: NEW TACOMA CEM

23d. LOCATION (City, town, or county) (State): TACOMA WASH

24. FUNERAL DIRECTOR ADDRESS: TOLL FUNERAL HOME TACOMA

25. DATE REC'D BY LOCAL REG.: DEC 3 1959

26. REGISTRAR'S SIGNATURE: C. R. Jaglen, M.D.

S. F. No. 7784—1-58—70M. 51916.