DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

REG'D SEP 15 1939

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 29029

Registration District No. 266 — Primary Registration District No. 5318 — Registrar's No. 73

1. PLACE OF DEATH:

(a) County: Dent 2

(b) City or town: Rural Watkins
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: XXXX
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution XXX (Specify whether years, months or days)

In this community All his life

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Dent

(c) City or town Rural
(If outside city or town limits, write "RURAL")

(d) Street No. XXX Route 4
(If rural, give location)

(e) If foreign born, how long in U. S. A.? XXX years.

3. (a) PRINT FULL NAME: Holice Kimber Bingham 525

3. (b) If veteran, name war XXX

3. (c) Social Security No. XXX

4. Sex: male

5. Color or race: White

6. (a) Single, widowed, married, divorced: single

6. (b) Name of husband or wife: XXX

6. (c) Age of husband or wife if alive: XX years

7. Birth date of deceased: June 18 1910 (Month) (Day) (Year)

8. AGE: Years 29 | Months 2 | Days 11 | If less than one day ____ hr. ____ min.

9. Birthplace: Dent Co (City, town, or county) Mo (State or foreign country)

10. Usual occupation: farmer

11. Industry or business: XX

MOTHER FATHER

12. Name: D. D. Bingham

13. Birthplace: Dent Co (City, town, or county) Mo (State or foreign country)

14. Maiden name: America Jane Teague

15. Birthplace: Dent Co (City, town, or county) Mo (State or foreign country)

16. (a) Informant's own signature: D. D. Bingham

(b) Address: Salem Mo route 4

17. (a) burial (Burial, cremation, or removal) (b) Date thereof 8/31/39 (Month) (Day) (Year)

(c) Place: burial or cremation: Anutt Cem

18. (a) Signature of funeral director: Earl L. Spencer

(b) Address: Salem Mo

19. (a) August 30 1939 (Date received local registrar) (b) F. E. Butler M.D. (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 29 year 1939 hour 3:00 P.M. minute ____ M.

21. I hereby certify that I attended the deceased from ←, 19__, to ←, 19__; that I last saw h← alive on ←, 19__; and that death occurred on the date and hour stated above.

Immediate cause of death: Cebrial Hemorrage Duration 15 min.

Due to: Over Heat-

Due to: Sun or Stroke

Other conditions (Include pregnancy within 3 months of death): ←

Major findings: Of operations: ←

Of autopsy: No

PHYSICIAN — Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify): ←

(b) Date of occurrence: ←

(c) Where did injury occur? ← (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)

While at work? ← (e) Means of injury ←

23. Signature: O. K. Dillon (M. D. or other) Coroner

Address: Salem Mo Date signed ____

(Licensed Embalmer's Statement on Reverse Side)

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

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

REV. 8-17-39
1 X19511

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, [redacted], Registered Apprentice No. ,

working under my personal supervision.

RECEIVED
District Health Officer No. 5,
District File Number 93 F 168
Date Filed 9 6 39

Signed Wm. W. McDonald
Licensed Embalmer No. 3806
P. O. Address Salem, 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 this body is not embalmed, above space should be left blank.