

FILED SEP 25 1940

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

30037

Do not use this space.

1. PLACE OF DEATH

(a) County Webster 2 Registration District No. 896
 (b) Township Ozark 0 Primary Registration District No. 6198 Registered No. 24
 (c) City Marshfield (d) Street No. _____
 (If death occurred in Hospital or Institution, write its name instead of street and number)
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U.S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

52 James William Bingaman, Jr.
 (a) Residence, No. _____ St. (If nonresident, give city or town and State)
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Unknown

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF X

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Unknown

7. AGE YEARS 36 MONTHS X DAYS X If LESS than 1 day, _____ hrs. or _____ min.

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Unknown
 9. Industry or business in which work was done, as saw mill, bank, etc. Unknown
 10. Date deceased last worked at this occupation (month and year) X 11. Total time (years) spent in this occupation X

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Unknown 7

FATHER 13. NAME Unknown JW Bingaman, Sr.

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) X 7

MOTHER 15. MAIDEN NAME Unknown

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) X 7

17. INFORMANT (ADDRESS) Papers in clothing of J.W. Edwards - Springfield, Missouri

18. BURIAL, CREMATION, OR REMOVAL PLACE Mt. Olive DATE May 17, 1940

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Tex Tamey Marshfield, Missouri

20. FILED Aug 10, 1940 Elizabeth Highfree Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) May 14, 1940

22. I HEREBY CERTIFY: That I attended deceased from _____, 19____, to _____, 19____

I last saw him _____ alive on _____, 19____. Death is said to have occurred on the date stated above, at 5:13 A.M.

The principal cause of death and related causes of importance were as follows:

STRUCK BY FRISCO PASSENGER NO. 3

CRUSHED HEAD AND DISSECTED BODY

Other contributory causes of importance: 207

Name of operation _____ Date of _____

What test confirmed diagnosis? _____ Was there an autopsy? No

23. If death was due to external causes (violence), fill in also the following:

Accident, suicide, or homicide? ACCIDENT Date of injury MAY 14, 1940

Where did injury occur? MARSHFIELD, MO.

(Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

FRISCO RIGHT OF WAY

Manner of injury CRUSHED HEAD AND

Nature of injury DISSECTED BODY

24. Was disease or injury in any way related to occupation of deceased?

If so, specify _____

(Signed) H.K. Kelly Coronar Webster, Mo.

(Address) Seymour Mo.

WRITE PLAINLY, WITH UNFADING INK--THIS IS 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

11 X14029

RECEIVED
District Health Officer No. 6,
District Health Officer No. 6,
District File Number
Date Filed

RECEIVED
District Health Officer No. 6,
District File Number 940-2590
Date Filed SEP 12 1940

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 _____

Registered Apprentice No. _____, working under my personal supervision.

Signed _____

Licensed Embalmer No. _____

P. O. Address _____

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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 30037

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. 896

Primary Registration District No. 6198

Registrar's No. _____

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

1. PLACE OF DEATH:

(a) County webster
(b) City or town Osark, Mo.
(c) Name of hospital or institution:
(If outside city or town limits, write "RURAL" and name of township)
(d) Length of stay: In hospital or institution _____
(Specify whether _____)
In this community _____
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State mo (b) County webster
(c) City or town Seymour, Mo
(If outside city or town limits write "RURAL")
(d) Street No. _____
(If rural, give location)
(e) If foreign born, how long in U. S. A. ? _____ years.

3. (a) PRINT FULL NAME

James W^m Bingham

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex m

5. Color or race w

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

6. (b) Name of husband or wife _____

6. (c) Age of husband, or wife, if alive _____ year

7. Birth date of deceased _____
(Month) (Day) (Year)

8. AGE: Years 36 Months _____ Days _____
If less than one day _____ hr. _____ min.

9. Birthplace _____
(City, town, or county) (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER

12. Name _____

13. Birthplace _____
(City, town, or county) (State or foreign country)

14. Maiden name _____

15. Birthplace _____
(City, town, or county) (State or foreign country)

16. (a) Informant _____
(b) Address _____

17. (a) _____ (b) Date thereof _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) 10-22-40 (b) Eugene Hoffman
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 14
year 1940 hour _____ 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 _____

Due to _____

Due to _____

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____

Of autopsy _____

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? _____

While at work? _____ (Specify type of place)
(e) Means of injury _____

23. Signature R. P. Kelley, Coroner (M.D. or other)

Address Seymour, Mo signed _____

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

SUPPLEMENTAL

