

No. 2
13-40
17-39
X23159

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 22106

Register District No. 508

Primary Registration District No. 3026

Registrar's No. 100

1. PLACE OF DEATH: Livingston
 (a) County Livingston
 (b) City or town Chillicothe
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: Chillicothe Hospital
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution. 3 days
 In this community 12 yrs.
 years, months or days (Specify whether)

3. (a) PRINT FULL NAME Charles Rufus Binford
 3. (b) If veteran, name war X
 3. (c) Social Security No. X

4. Sex Male
 5. Color or race White
 6. (a) Single, widowed, married, divorced Divorced
 6. (b) Name of husband or wife Blanche Binford
 6. (c) Age of husband or wife if alive 53 years
 7. Birth date of deceased December 2, 1871
 (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
69 7 3 X hr. X min.

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

10. Usual occupation Carpenter

11. Industry or business _____

MOTHER FATHER { 12. Name David Binford
 13. Birthplace _____ Penn.
 (City, town, or county) (State or foreign country)
 14. Maiden name Tamar Howkins
 15. Birthplace _____ Ind.
 (City, town, or county) (State or foreign country)

16. (a) Informant Fern Kaye
 (b) Address 5916 N. 16th St, Arlington, Va.

17. (a) Burial
 (Burial, cremation, or removal) (b) Date thereof 7/10/41
 (Month) (Day) (Year)
 (c) Place: burial or cremation Grant City, Mo.

18. (a) Signature of funeral director James Gordon
 (b) Address Chillicothe, Mo.

19. (a) _____ (b) _____
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
 (a) State Missouri (b) County Livingston
 (c) City or town Chillicothe
 (If outside city or town limits, write "RURAL")
 (d) Street No. None
 (If rural, give location)
 (e) If foreign born, how long in U. S. A. ? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 5
 year 1941 hour 8 minute _____ A. M.

21. I hereby certify that I attended the deceased from July 3, 1941, to July 5, 1941,
 that I last saw him alive on July 4, 1941,
 and that death occurred on the date and hour stated above.

Immediate cause of death Coronary Thrombosis
 Due to _____

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

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?
943
 (Specify type of place) _____
 While at work? _____ (e) Means of injury _____

23. Signature A. Puller (M. D. or other) O
 Address Chillicothe, Mo. Date signed 7/7/41

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

59
1
2

FILED JUL 17 1941
508

59
1
2

Duration

2.5 day

PHYSICIAN

Underline the cause to which death should be charged statistically.

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 Ronald F. Gordon

Licensed Embalmer No. 4191

P. O. Address Chillicothe, 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, fact should be so stated above.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

Registration District No. 508

Primary Registration District No. 3026

Registrar's No. _____

1. PLACE OF DEATH Livingston

(a) County _____

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

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

(d) Length of stay: In hospital or institution _____
(Specify whether _____)

In this community _____
years, months or days

3. (a) PRINT FULL NAME Charles Rufus Binford

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

5. Color or race _____

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

6. (b) Name of husband or wife _____

6. (c) Age of husband or wife if alive _____ years _____ months _____ days

7. Birth date of deceased Dec 2 1871
(Month) (Day) (Year)

8. AGE: Years _____ 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) 7-8-41 (b) T. M. Brac...
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____

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

(d) Street No. _____
(If rural, give location)

(e) Citizen of foreign country _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH Month July day 5
year 1941 hour _____ minute _____ M.

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

Immediate cause of death _____

Duration _____

Due to _____

Due to _____

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

Major findings:
Of operations _____

Of autopsy _____

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? _____

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

(a) Signature _____ (M. D. or other) _____

(b) Address _____ Date signed _____

SUPPLEMENTAL

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

