

FILED MAY 31 1944

Registration District No. 1000

Primary Registration District No. 1000

Registrar's No. 538

1. PLACE OF DEATH:

(a) County Buchanan  
(b) City or town St Joseph  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
1024 Douglas  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution Fair  
(Specify whether)

In this community 1  
years, months or days

3. (a) PRINT FULL NAME

Olden Binn

3. (b) If veteran, name war

3. (c) Social Security No. No.

4. Sex Male Color or race Colored

6. (a) Single, widowed, married, divorced 9

6. (b) Name of husband or wife Marcie Binn

6. (c) Age of husband or wife if alive 0 years

7. Birth date of deceased April 1902  
(Month) (Day) (Year)

8. AGE: Years 42 Months 1902 Days April  
If less than one day hr. min.

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

10. Usual occupation

11. Industry or business

MOTHER FATHER {  
12. Name: Charles Binn  
13. Birthplace Macon Mo  
(City, town, or county) (State or foreign country)  
14. Maiden name Maggie Clay  
15. Birthplace Easter Mo  
(City, town, or county) (State or foreign country)

16. (a) Informant Josie Stone  
(b) Address 1024 Douglas St.

17. (a) Burial (b) Date thereof May 27 44  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Ashland

18. (a) Signature of funeral director Beatrice Gray  
(b) Address 812 Pacific

19. (a) 5/26/44 (b) Nelen J. Coker  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Buchanan  
(c) City or town St Joseph  
(If outside city or town limits, write "RURAL")  
(d) Street No. 1024 Douglas  
(If rural, give location)  
(e) Citizen of foreign country? No. (Yes or No)  
If yes, name country Mo

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 25  
year 1944 hour 2 minute 30 A.M.

21. I hereby certify that I attended the deceased from May 22  
1944 to May 22 1944  
that I last saw him alive on May 22  
and that death occurred on the date and hour stated above.

Immediate cause of death Cardiac Decompression  
Duration 1

Due to Acute Sepsis

Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations r

Of autopsy r

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 VO

23. Charles J. C. Werner D. O. M. 1926  
Address 221 Kirkwood Bldg Date signed 5-26-1944

1377

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

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 May 25

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

Signed Elena Clark

Licensed Embalmer No. 4235

P. O. Address St. Joseph M

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.

Registration District No. 42

Primary Registration District No. 1000

Registrar's No. 538

1. PLACE OF DEATH:

(a) County Buchanan

(b) City or town St. Joseph  
(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 10 years (Specify whether years, months or days)

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 \_\_\_\_\_

3. (a) PRINT FULL NAME Olden Levin

3. (b) If veteran, name war \_\_\_\_\_

3. (c) Social Security No. (unable to locate as of 1/4/42)

4. Sex M

5. Color or race B

6. (a) Single, widowed, married, divorced married 30 years divorced 30 1/2 years

6. (b) Name of husband or wife \_\_\_\_\_

6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased: April (Month) 13 (Day) 1902 (Year)

8. AGE: Years 42 Months \_\_\_\_\_ Days \_\_\_\_\_ Unless than one day \_\_\_\_\_ min.

9. Birthplace \_\_\_\_\_ (City, town, or county) Mo. (State or foreign country)

10. Usual occupation Driver for Peaty Bakery, 5th & Mitchell

11. Industry or business \_\_\_\_\_

12. Name \_\_\_\_\_

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

14. Maiden name \_\_\_\_\_ (City, town, or county) \_\_\_\_\_ (State or foreign country)

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

16. (a) Informant \_\_\_\_\_ (b) Address \_\_\_\_\_

17. (a) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_ (Month) (Day) (Year)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_ (b) Address \_\_\_\_\_

19. (a) \_\_\_\_\_ (b) Levin L. Pickle (Registrar's signature) (Date received local registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 15 year 1942 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_; that I last saw him/her 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? \_\_\_\_\_ (Specify type of place) (e) Means of injury \_\_\_\_\_

23. Signature \_\_\_\_\_ (M. D. or other) \_\_\_\_\_ Address \_\_\_\_\_ Date signed \_\_\_\_\_

Duration \_\_\_\_\_ PHYSICIAN \_\_\_\_\_ Underline the cause to which death should be charged statistically.

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

SUPPLEMENTARY

JUN 24 1944

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