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M-2-43
v. 5-17-39
X35697

FILED MAR 14 1945

State File No. _____

Registration District No. 107

Primary Registration District No. 3019

Registrar's No. 14

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

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Dunklin
(c) City or town Deering (If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME GAILON BINKLEY

MEDICAL CERTIFICATION

3. (b) If veteran, name war No 3. (c) Social Security No. None

20. DATE OF DEATH: Month 2 day 8
year 1945 hour 8 minute 15 P.M.

4. Sex Male 5. Color or race White

21. I hereby certify that I attended the deceased from 2-7-45
2-8, 1945, to _____, 1945;
that I last saw him alive on 2-8, 1945;
and that death occurred on the date and hour stated above.

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if
alive _____ years

Immediate cause of death Cerebral Hemorrhage Duration _____

7. Birth date of deceased May 27 1944
(Month) (Day) (Year)

Due to traumatic

8. AGE: Years _____ Months 8 Days 11
If less than one day _____ hr. _____ min.

Due to _____

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

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

10. Usual occupation Minor

Major findings: Of operations _____

11. Industry or business _____

Of autopsy _____

PHYSICIAN _____

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

Underline the cause to which death should be charged statistically.

12. Name Dwight C. Binkley

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

14. Maiden name Maxine Naile

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

16. (a) Informant Maxine Binkley
(b) Address Deering, Mo.

17. (a) Burial (b) Date thereof 2/11/45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Stanfield, Mo.

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? _____

18. (a) Signature of funeral director F. S. Smith Funeral Home
(b) Address Caruthersville, Mo.

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

19. (a) 2-11-45 (Date received local registrar) J. S. Smith (Registrar's signature)

23. Signature E. C. Wilson (M. D. or other) MD
Address Kennett, Mo. Date signed 2-8-45

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

2
2

901

RECEIVED

District Health Office No.

District File Number 345-3

Date Filed 3/8/4

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..... *E. E. White*.....

Licensed Embalmer No. 4168.....

P. O. Address Lebanonville, 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.