

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED DEC 12 1945 STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

37100

State File No.

Registration District No.

Primary Registration District No.

Registrar's No. ~~10~~ 7

1. PLACE OF DEATH:
 (a) County..... FRANKLIN
 (b) City or town..... SULLIVAN (Rural)
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: 1
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution.....
 In this community..... 82 Years. (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:
 (a) State..... MISSOURI (b) County..... FRANKLIN
 (c) City or town..... Sullivan, (Rural)
(If outside city or town limits, write "RURAL")
 (d) Street No.....
(If rural, give location)
 (e) Citizen of foreign country?..... 0 (Yes or No)
 If yes, name country.....

3. (a) PRINT FULL NAME. John George Bindner
 3. (b) If veteran, name war..... No
 3. (c) Social Security No..... None

MEDICAL CERTIFICATION
 20. **DATE OF DEATH:** Month November Day 26
 year 1945 hour 2 minute 55 PM.
 21. I hereby certify that I attended the deceased from Nov 23 1945 to Nov 26 1945
 that I last saw h..... alive on..... 19.....
 and that death occurred on the date and hour stated above.

4. Sex Male
 5. Color or race White
 6. (a) Single, widowed, married, divorced, Widowed
 6. (b) Name of husband or wife.....
 6. (c) Age of husband or wife if alive..... years

Immediate cause of death.....
Acute Cholecystitis 4 da

7. Birth date of deceased JULY 26 1863
(Month) (Day) (Year)
 8. **AGE:** Years 82 Months 4 Days
 If less than one day hr. min.

Due to.....
 Due to.....
 Other conditions (Include pregnancy within 3 months of death).....
 Major findings: Of operations.....
 Of autopsy.....
 Duration 4 da
 Physician Not Known
 Underline the cause to which death should be charged statistically.

9. Birthplace..... Jeffriesburg, Missouri
(City, town, or county) (State or foreign country)
 10. Usual occupation..... Farming
 11. Industry or business..... Farming
 12. Name..... Peter Bindner
 13. Birthplace..... Germany
(City, town, or county) (State or foreign country)
 14. Maiden name..... Weisart
 15. Birthplace..... Germany
(City, town, or county) (State or foreign country)

16. (a) Informant..... Mrs. B. S. West
 (b) Address..... Sullivan, Missouri
 17. (a) Burial (b) Date thereof Nov. 28,
(Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation..... Japan Cemetery
 18. (a) Signature of funeral director.....
 (b) Address..... Sullivan, Missouri.
 19. (a) 11-27-45 (b) [Signature]
(Date received local registrar) (Registrar's signature)

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..... [Signature]
 Address..... Beaufort Mo Date signed..... 11-27-45

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

MOTHER FATHER

155 X

RECEIVED

District Health Officer No. 9,

District File Number _____

Date Filed 12-11-45

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

Edgar W. Laffoon

Licensed Embalmer No. 3294
P. O. Address Sullivan

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. (112)

Primary Registration District No. (3428)

1. PLACE OF DEATH:
 (a) County Franklin
 (b) City or town Brown Sulphur
(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)

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 John D. Bidner
 3. (b) If veteran, name war..... 3. (c) Social Security No.....

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month July Day 26 Year 1941 hour..... minute..... M.
 21. I hereby certify that I attended the deceased from..... 19.....
 that I last saw him..... alive on..... 19.....
 and that death occurred on the date and hour stated above.
 Immediate cause of death.....

4. Sex m 5. Color or race w
 6. (a) Single, widowed, married, divorced wid

6. (b) Name of husband or wife..... 6. (c) Age of husband or wife if alive..... years
 7. Birth date of deceased July 26
(Month) (Day) (Year)

8. AGE: Years 82 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.....

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)..... (b) [Signature]
(Date received local registrar) (Registrar's signature)

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?
(Specify type of place)
 While at work?..... (c) Means of injury.....

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

SUPPLEMENTARY

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

MOTHER FATHER

37100

~~W. J. G. M. L.~~