

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **42150**

FILED DEC 17 1947

Registration District No. **169**

Primary Registration District No. **4258**

Registrar's No. **181**

1. PLACE OF DEATH:

(a) County **Knox**
(b) City or town **Edina**
(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 **76 yrs.**
years, months or days

3. (a) PRINT NAME **Anna Regina Elizabeth Binkley**
FULL NAME

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

4. Sex **F** 5. Color or race **W** 6. (a) Single, widowed, married, divorced. **married**

6. (b) Name of husband or wife. **Geo. F. Binkley** 6. (c) Age of husband or wife if alive. **74** years

7. Birth date of deceased **Nov - 25 - 1871**
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
76 **0** **8** hr. min.

9. Birthplace **Hamilton** **Illinois**
(City, town, or county) (State or foreign country)

10. Usual occupation **Homekeeper**

11. Industry or business

12. Name **John Schlagel**
13. Birthplace **uk** **Switzerland**
(City, town, or county) (State or foreign country)
14. Maiden name **Barbara Glopchair**
15. Birthplace **uk** **Switzerland**
(City, town, or county) (State or foreign country)

16. (a) Informant **Barbara Kincaid**
(b) Address **Edina, Mo.**

17. (a) **Burial** (b) Date thereof **Dec-6-1947**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Beeridge, Knox Co. Mo.**

18. (a) Signature of funeral director **Robert H. Hudson**

(b) Address **Edina, Mo.**

19. (a) **Dec-2-47** (b) **Will S. Nunn**
(Data received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Knox**
(c) City or town **Edina**
(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 **Dec** day **3**
year **1947** hour **9** minute **45** P.M.

21. I hereby certify that I attended the deceased from **Sept 1**, 1945, to **Dec 3**, 1947
that I last saw her alive on **Dec 3**, 1947
and that death occurred on the date and hour stated above.

Immediate cause of death **Cerebral Hemorrhage** **6 days**

Due to **Hypertension** **3 years**

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) (c) Means of injury

23. Signature **J. B. Bunkley** (M. D. or other) **D.O.**
Address **Edina, Mo.** Date signed **12/4/47**

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

JAY 21 1954

RECEIVED
District Health Officer No. 40
District File Number 12-47-1772
Date Filed DEC 16 1947

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. 2415

P.O. Address

Eolina, Missouri

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.