

No. 2
1-47
17-39

FEDERAL SECURITY AGENCY
National Office of Vital Statistics
FILED FEB 11 1948
Registration District No. 70

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 1621
Registrar's No. 777

Primary Registration District No. 3633

1. PLACE OF DEATH:

(a) County Laclede
(b) City or town Lebanon
(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 few weeks (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Laclede 53
(c) City or town Brownfield
(If outside city or town limits, write "RURAL")
(d) Street No. R.R. (If rural, give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country.....

3. (a) PRINT FULL NAME George Harvey Bingham
3. (b) If veteran, name war.....
3. (c) Social Security No.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan. day 26
year 1948 hour 2 minute A.M.
21. I hereby certify that I attended the deceased from on Dec 16 only 1948 to Dec 16 1948
that I last saw him alive on Dec 16 1948
and that death occurred on the date and hour stated above.
Immediate cause of death cerebral hemorrhage
Duration

4. Sex M 5. Color or race W
6. (a) Single, widowed, married, divorced married
6. (b) Name of husband or wife Nancy Susan
6. (c) Age of husband or wife if alive 77 years
7. Birth date of deceased Dec. 18, 1866
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>81</u>	<u>1</u>	<u>8</u>hr.min.

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

10. Usual occupation Retired Farmer

11. Industry or business Farm

12. Name Mansfield Edward Bingham

13. Birthplace Laclede Co. Mo.
(City, town, or county) (State or foreign country)

14. Maiden name Martha Ware

15. Birthplace Laclede Co. Mo.
(City, town, or county) (State or foreign country)

16. (a) Informant Curtis Wilson (grandson)
(b) Address Brownfield Mo.

17. (a) Burial (b) Date thereof 1-28-48
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Cross Roads

18. (a) Signature of funeral director W.E. Holman
(b) Address Lebanon, Mo.

19. (a) 2-7-48 (b) Tressie B. Lynley
(Date received local registrar) (Registrar's signature)

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

Major findings:
Of operations.....
Of autopsy.....

PHYSICIAN
Underline the cause of 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?.....
Means of injury.....
23. Signature A. L. Anthony (M. D. over)
Address Oakland Mo Date signed 1/27/48

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

MOTHER FATHER

Received 2/10/48

County Health Unit

File No. 1-48-11

Date filed 2/10/48

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 *Dorsey M. Howe*

Licensed Embalmer No. *4222*

P. O. Address *Lebanon, 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.

Registration District No. 170

Primary Registration District No. 2003

1. PLACE OF DEATH:

(a) County Todd
(b) City or town Lebanon
(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 George H. Bughian

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

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

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

7. Birth date of deceased see (Month) (Day) (Year) 18

8. AGE: Years 81 Months _____ Days _____ If less than one day _____ hr. _____ min.

9. Birthplace _____ (City, town, or county) (State or foreign country) No

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) _____ (Burial, cremation, or removal) (b) Date thereof _____ (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) 2/7/48 (b) Lois P. Lynch (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 _____ Day _____ Year 1948 Hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ 19 _____ to _____ 19 _____

that I last saw him _____ 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 _____

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

Date signed _____

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

SUPPLEMENTARY

S-1621