

Health, Welfare, Public Service

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-57

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

All diseases in Part I must be causally related.

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED JUL 16 1957

27238

STATE FILE NUMBER

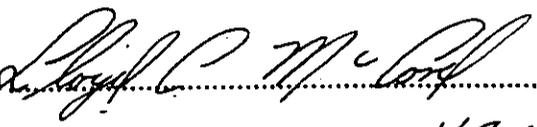
Registration District No. 360 Primary Registration District No. 3076 Registrar's No. 122

1. PLACE OF DEATH a. COUNTY <u>Vernon</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>Vernon</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Nevada</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>Nevada</u> 10826 Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF HOSPITAL OR INSTITUTION <u>Home Under Son Nursing 507 So. Cedar</u> Length of stay in lb <u>3 yrs.</u>		d. STREET ADDRESS (If outside, give location) <u>507 So. Cedar</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>ARIE</u> Middle <u>A.</u> Last <u>BINGAMAN</u>			4. DATE OF DEATH Month <u>July</u> Day <u>3</u> Year <u>1957</u>
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>14 April 1871</u>
9. AGE (In years and birthday) <u>86</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	11. BIRTHPLACE (City and state or country) <u>Webster, Co, Mo</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Housewife</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13a. FATHER'S NAME <u>John Farkess</u>		13b. MOTHER'S MAIDEN NAME <u>Mary A. McCurey</u>	14. NAME OF HUSBAND OR WIFE <u>UNK NOW</u>
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	17. INFORMANT <u>Henry Samuel</u> Address <u>Deuda, Mo.</u>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u>			INTERVAL BETWEEN ONSET AND DEATH <u>1 wk.</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Don't know</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
DUE TO (c) <u>Don't know</u> <u>331. X</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I. (a) <u>Advanced age</u>			
20a. ACCIDENT SUICIDE HOMICIDE <u>None</u>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) <u>None</u>	
20c. TIME OF INJURY Hour Month Day, Year <u>None</u>			
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>None</u>	
20f. CITY, TOWN, OR LOCATION <u>Nevada</u>		COUNTY <u>Vernon</u> STATE <u>Mo.</u>	
21. I attended the deceased from <u>June 28/57</u> to <u>July 3/57</u> and last saw her alive on <u>June 28/57</u> . Death occurred at <input checked="" type="checkbox"/> m of the date stated above; and to the best of my knowledge from the causes stated.			
22a. SIGNATURE <u>W. Love</u> (Degree or title)		22b. ADDRESS <u>Nevada, Mo</u>	
22c. DATE SIGNED <u>7-3-57</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>7-5-57</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Thom Grove</u>		23d. LOCATION (City, town, or county) (State) <u>Dunnagan, Mo.</u>	
24. FUNERAL DIRECTOR <u>Richard H. Shotton</u> ADDRESS <u>Nevada, Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>7-10-1957</u>	
26. REGISTRAR'S SIGNATURE <u>Anna E. Ferry</u>			

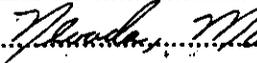
STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed
by me, or by, Student Embalmer No.
working under my personal supervision.

Student
Signature of Student Embalmer

Signed 

Licensed Embalmer No. 4853

P. O. Address 

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.