

Health, Welfare  
Public Service

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-040343

STATE FILE NUMBER

FILED DEC 2 1958

Registration District No. 146 Primary Registration District No. 55-68 Registrar's No. 497

300  
1-57

1. PLACE OF DEATH a. COUNTY <b>Jackson</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Jackson</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Blue Township</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>Kansas City 22,</b> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>10023 Wilson Rd.</b>		Length of stay in lb <b>1 1/2 yrs.</b>	d. STREET (If outside, give location) ADDRESS <b>10023 Wilson Road</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print)			4. DATE OF DEATH		
First <b>VERGIE</b>	Middle <b>C.</b>	Last <b>BINNIE</b>	Month <b>Nov.</b>	Day <b>Unknown,</b>	Year <b>1958</b>

5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 15, 1890</b>	9. AGE (In years last birthday) <b>68</b>	10. UNDER 1 YEAR Months	11. UNDER 24 HRS. Days	Hours	Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Domestic</b>	11. BIRTHPLACE (City and state or country) <b>Dighton, Kansas</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
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13a. FATHER'S NAME <b>William J. Brockman</b>	13b. MOTHER'S MAIDEN NAME <b>Katherine Brockman</b>	14. NAME OF HUSBAND OR WIFE <b>Stephen Binnie</b>
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>	16. SOCIAL SECURITY NO. <b>493-32-4591B</b>	17. INFORMANT <b>Mrs. Ruth I. Scogin, 11511 Hackett, Sugar Crk. Mo.</b>	Address
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carbon Monoxide Poisoning</b>		INTERVAL BETWEEN ONSET AND DEATH <b>8900 15</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) _____	19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
	DUE TO (c) _____	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		

20a. ACCIDENT <input checked="" type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury if PART I or PART II of item 18.) <b>Seats caused by fumes from cemented stone</b>
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20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year <b>123</b>	20d. INJURY OCCURRED WHILE AT WORK <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.) <b>Home</b>	20f. CITY, TOWN, OR LOCATION <b>Kansas City, Missouri</b>	COUNTY <b>Missouri</b>	STATE <b>Missouri</b>
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21. I attended the deceased from \_\_\_\_\_ to \_\_\_\_\_ and last saw her/him alive on \_\_\_\_\_  
Death occurred at \_\_\_\_\_ m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <b>Geo C. Carson</b> (Degree or title)	22b. ADDRESS <b>6627 Hackett St. Mo.</b>	22c. DATE SIGNED <b>11-28-58</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>12-1-58</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Md. Grove Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>Independence, Mo.</b>
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24. FUNERAL DIRECTOR <b>Geo. C. Carson &amp; Sons, Indep., Mo.</b>	ADDRESS	25. DATE RECD. BY LOCAL REG. <b>12-1-58</b>	26. REGISTRAR'S SIGNATURE <b>[Signature]</b>
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USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

All diseases in Part I must be causally related.

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

*Not Embalmed*  
Signed *H. Gibson* .....  
Licensed Embalmer No. *4811* .....  
P. O. Address *Indep. 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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.