DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED JUL 17 1940

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 21447

Registration District No. 133 | Primary Registration District No. 5185 | Registrar's No. 8

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

1. PLACE OF DEATH:
(a) County: Carroll Sixth Ju.
(b) City or town: (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) 25 days

2. USUAL RESIDENCE OF DECEASED:
(a) State: Missouri (b) County: Carroll
(c) City or town: Rural (If outside city or town limits, write "RURAL")
(d) Street No.: Rural (If rural, give location)
(e) ~~If foreign born~~, how long in U. S. A.? 86 years.

3. (a) PRINT FULL NAME: Joseph Green Bingham.
3. (b) If veteran, name war: No
3. (c) Social Security No.: 4 no
4. Sex: Male
5. Color or race: White
6. (a) Single, widowed, married, divorced: Widower
6. (b) Name of husband or wife: Dead
6. (c) Age of husband or wife if alive: years
7. Birth date of deceased: Oct (Month) 25 (Day) - 1853 (Year)

8. AGE: Years: 86 | Months: 7 | Days: 11 | If less than one day: hr. min.

9. Birthplace: Carroll Co. Mo (City, town, or county) (State or foreign country)
10. Usual occupation: Farming
11. Industry or business:
FATHER
12. Name: David Bingham
13. Birthplace: Penn (City, town, or county) (State or foreign country)
MOTHER
14. Maiden name: Hartless
15. Birthplace: ~~Carroll~~ (City, town, or county) Penn (State or foreign country)
16. (a) Informant: Clyde Bingham
(b) Address: Bogard mo
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/18/40 (Month) (Day) (Year)
(c) Place: burial or cremation: Colonia mo
18. (a) Signature of funeral director: Ed Dickerson
(b) Address: Bogard mo
19. (a) 6-18-1940 (Date received local registrar) (b) Jamie Henderson (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 16 year 1940 hour 3 minute 0 A. M.
21. I hereby certify that I attended the deceased from May 18, 1940 to 6-16, 1940 that I last saw him alive on 5-18- 1940 and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Hypostatic Pneumonia (Broncho-pneumonia)	1 wk
Due to Fracture right femur	
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: W. G. Atwood (M. D. or other) M
Address: Carrollton mo Date signed 6/18/40

(Licensed Embalmer's Statement on Reverse Side)

1448 69

RECEIVED
District Health Officer No. 8,
District File Number
Date Filed 7-15-48

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 E A Dickerson

Licensed Embalmer No. 2534

P. O. Address Bay mdw Md

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, above space should be left blank.

S. No. 2B
M—2-21-40
I X22659

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 21447

Registration District No. 122 — Primary Registration District No. 5185 — Registrar's No. 8

1. PLACE OF DEATH:

(a) County Carroll

(b) City or town Linden Twp.
(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 years, months or days)
In this community

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) If foreign born, how long in U. S. A.? years.

3. (a) PRINT FULL NAME Joseph Green Bingham

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 wid

6. (b) Name of husband or wife

6. (c) Age of husband, or wife, if alive years

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

8. AGE: Years 86 | Months 7 | Days 11 | If less than one day hr. min.

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

10. Usual occupation

11. Industry or business

MOTHER FATHER

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) (Date received local registrar) (b) (Registrar's signature)

SUPPLEMENTARY

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 16
year 1940 hour minute M.

21. I hereby certify that I attended the deceased from , 19, to , 19;
that I last saw h alive on , 19;
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Hypostatic Pneumonia	
Due to Fracture of femur	
Due to Fall	
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) accident
(b) Date of occurrence 5-11-40
Nell Bogard, was Horace Carrollton Mo
(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? about house
(Specify type of place)
While at work? yes (e) Means of injury Fall

23. Signature W. G. Atwood (M. D. or other)
Address Carrollton Mo. Date signed