

REC'D JUN 23 1938

MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH

Do not use this space.

19128

1. PLACE OF DEATH

County *Dennis*

Township *Little Prairie*

City *Carricksville*

Registration District No. *65-1*

Primary Registration District No. *9862*

File No.

Registered No. *48*

St.

Ward

2. FULL NAME

(a) Residence, No. *Home*

(Usual place of abode)

St.

Ward.

(If nonresident, give city or town and State)

Length of residence in city or town where death occurred *10* yrs. mos. ds.

How long in U. S., if of foreign birth? *524* yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *M*

4. COLOR OR RACE *White*

5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) *Widowed*

5A. IF MARRIED, WIDOWED, OR DIVORCED, HUSBAND OF (OR) WIFE OF *Mr. J. H. Binkley*

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) *Unknown*

7. AGE

YEARS *66*

MONTHS *-*

DAYS *-*

If LESS than 1 day, ..... hrs. or ..... min.

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. *None*

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. *None*

10. Date deceased last worked at this occupation (month and year) *None*

11. Total time (years) spent in this occupation *Life*

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Not known*

13. NAME *-*

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *-*

15. MAIDEN NAME *-*

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *-*

17. INFORMANT (ADDRESS) *Friends Carricksville, Mo.*

18. BURIAL, CREMATION, OR REMOVAL PLACE *Mounts May 23 38*

19. UNDERTAKER (ADDRESS) *Friends Carricksville, Mo.*

20. FILED *May 23 1938*

*Ada Martin* Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *May 22 1938*

22. I HEREBY CERTIFY That I attended deceased from *May 22 1938* to *May 23 1938*

I last saw him alive on *May 22 1938* Death is said

to have occurred on the date stated above, at *2 a. m.*

The principal cause of death and related causes of importance were as follows:

*Multiple Sarcoma* Date of onset *Not known*

Other contributory causes of importance:

Name of operation *None* Date of *-*

What test confirmed diagnosis? *-* Was there an autopsy? *NO*

23. If death was due to external causes (violence), fill in also the following:

Accident, suicide, or homicide? *-* Date of injury *-*, 19 *-*

Where did injury occur? *-* (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury *-*

Nature of injury *-*

24. Was disease or injury in any way related to occupation of deceased? *Health Officer*

If so, specify *Health Officer*

(Signed) *Fredh. Ogelove* M. D.

(Address) *Carricksville Mo*



**MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH**

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

**1. PLACE OF DEATH**

County Pemiscot  
Township \_\_\_\_\_  
City \_\_\_\_\_

Registration District No. 651  
Primary Registration District No. 5862-

File No. 19128-  
Registered No. \_\_\_\_\_  
St. \_\_\_\_\_ Ward \_\_\_\_\_

**2. FULL NAME**

Harve H. Binkler

(a) Residence, No. \_\_\_\_\_ St. \_\_\_\_\_ Ward \_\_\_\_\_  
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident, give city or town and State)

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX m 4. COLOR OR RACE w 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED w (write the word)

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF \_\_\_\_\_

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) \_\_\_\_\_

7. AGE YEARS MONTHS DAYS If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min. 66 - - -

OCCUPATION 8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. \_\_\_\_\_  
9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. \_\_\_\_\_  
10. Date deceased last worked at this occupation (month and year) \_\_\_\_\_ 11. Total time (years) spent in this occupation \_\_\_\_\_

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) \_\_\_\_\_

MOTHER 13. NAME \_\_\_\_\_

FATHER 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) \_\_\_\_\_

MOTHER 15. MAIDEN NAME \_\_\_\_\_

FATHER 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) \_\_\_\_\_

17. INFORMANT (ADDRESS) \_\_\_\_\_

18. BURIAL, CREMATION, OR REMOVAL PLACE \_\_\_\_\_ DATE \_\_\_\_\_ 19

19. UNDERTAKER (ADDRESS) \_\_\_\_\_

20. FILED \_\_\_\_\_ 19 \_\_\_\_\_

**MEDICAL CERTIFICATE OF DEATH**

21. DATE OF DEATH (MONTH, DAY, AND YEAR) May 23 1939

22. I HEREBY CERTIFY, That I attended deceased from \_\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_  
I last saw h. \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_. Death is said to have occurred on the \_\_\_\_\_ specified above, at \_\_\_\_\_ m.

The principal cause of death and related causes of importance were as follows:

Multiple Myeloma  
Back & neck  
Below left ear  
Date of onset \_\_\_\_\_  
Other contributory causes of importance: \_\_\_\_\_

Name of operation \_\_\_\_\_ Date of \_\_\_\_\_  
What test confirmed diagnosis? \_\_\_\_\_ Was there an autopsy? \_\_\_\_\_

23. If death was due to external causes (violence), fill in also the following: Accident, suicide, or homicide? \_\_\_\_\_ Date of injury \_\_\_\_\_, 19\_\_\_\_

Where did injury occur? \_\_\_\_\_ (Specify city or town, county, and State)  
Specify whether injury occurred in industry, in home, or in public place. \_\_\_\_\_

Manner of injury \_\_\_\_\_  
Nature of injury \_\_\_\_\_

24. Was disease or injury in any way related to occupation of deceased? \_\_\_\_\_  
If so, specify \_\_\_\_\_

(Signature) Fred L. Ogilvie, H. Officer  
(Address) Cornthursville, Mo

Registrar.

SUPPLEMENTARY

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

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