

ED SEP 9 1943
Registration District No. 38

Primary Registration District No. 2006

State File No. _____

Registrar's No. 207

1. PLACE OF DEATH:
(a) County Boone
(b) City or town Columbia MO
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Willie Conalescent Home
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether
In this community Life years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Boone
(c) City or town Columbia
(If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME George Bainbridge
3. (b) If veteran, name war x
3. (c) Social Security No. Y

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Aug day 20
year 1943 hour 7.50 minute _____ P. M.

4. Sex Male
5. Color or race White
6. (a) Single, widowed, married, divorced Single
6. (b) Name of husband or wife _____
6. (c) Age of husband or wife if alive _____ years

21. I hereby certify that I attended the deceased from March 1943 to Aug 7 1943
that I last saw him alive on Aug 7 1943
and that death occurred on the date and hour stated above.
Immediate cause of death _____

7. Birth date of deceased: Oct 7 1865
(Month) (Day) (Year)
8. AGE: Years 77 Months 10 Days 13
If less than one day hr. _____ min. _____

Duration
Paralysis
Due to Stroke
Due to General Arteriosclerosis

9. Birthplace Boone Co Mo
(City, town, or county) (State or foreign country)
10. Usual occupation laborer

Other conditions (Include pregnancy within 3 months of death)
Smoked for years
Major findings:
Of operations _____
Of autopsy _____

MOTHER FATHER
11. Industry or business _____
12. Name Jim Bainbridge
13. Birthplace England
(City, town, or county) (State or foreign country)
14. Maiden name Sara Williams
15. Birthplace Missouri
(City, town, or county) (State or foreign country)

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? _____

16. (a) Informant Ten Williams
(b) Address W Broadway
17. (a) Burial (b) Date thereof Aug 22 1943
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Nashville Tenn
18. (a) Signature of funeral director Roussell
(b) Address Columbia Mo
19. (a) Aug 21 43 (b) _____
(Date received local registrar) (Registrar's signature)

While at work? _____ (Specify type of place)
(c) Means of injury _____
23. Signature Stephen D. Hunt (M. D. or other) _____
Address Columbia Date signed 8/21

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.....

working under my personal supervision.

Registered Apprentice No. 318

Signed.....

Licensed Embalmer No. 318

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to complete the above constitutes grounds for revocation of license.)

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

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____

Registration District No. 38

Primary Registration District No. 3006

Registrar's No. 207

SEP 9

1. PLACE OF DEATH:

(a) County Boone
(b) City or town Columbia
(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 _____ (Specify whether _____ years, months or days)

3. (a) PRINT FULL NAME George Bainbridge

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 _____

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

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

8. AGE: Years 77 Months _____ Days _____ (If less than one day _____ min.)

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

10. Usual occupation _____

11. Industry or business _____

12. Name _____

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

14. Maiden name _____ (City, town, or county) (State or foreign country)

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) 9/25/43 (Date received local registrar) (b) [Signature] (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 _____ Hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____; that I last saw him _____ alive on _____, 19____; and that death occurred on the date and hour stated above. Immediate cause of death _____

Paralysis
stroke
Due to General arteriosclerosis
Called Dr. Smith
Due to and he informed me the
death was paralysis was caused
Other conditions by heritage of brain
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____
Curious sleeping position
Of autopsy _____
8301

Duration _____
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)
(b) Months of injury _____
23. Signature [Signature] (M. D. or other) _____
Address Columbia Mo Date signed _____

SUPPLEMENTARY

FATHER

27637