

S. No. 2
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5-17-39
PI X47070

DEPARTMENT OF COMMERCE
BUREAU OF LICENSING
FILED AUG 5 1946

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

22716

State File No.

Registration District No. 42

Primary Registration District No. 1000

Registrar's No. 870

1. PLACE OF DEATH:

(a) County Buchanan
(b) City or town St. Joseph
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Mo. Methodist Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 5 days
(Specify whether years, months or days) Entire life

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Clinton 25
(c) City or town GOWEN MO
(If outside city or town limits, write "RURAL")
(d) Street No. 1
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country.....

3. (a) PRINT FULL NAME SAMUEL BINSTEAD

3. (b) If veteran, name war.....
3. (c) Social Security No. 49-128-1368

4. Sex Male 5. Color or race White
6. (a) Single, widowed, married, divorced married

6. (b) Name of husband or wife Annie M Binstead
6. (c) Age of husband or wife if alive 63 years

7. Birth date of deceased July 18 1874
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
72 0 11 hr. min.

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

10. Usual occupation Farming

11. Industry or business.....

12. Name Emmanuel Binstead 4

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

14. Maiden name Anna Hawkins

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

16. (a) Informant Mo Annie M Binstead
(b) Address GOWEN MO

17. (a) Burial (b) Date thereof July 31-1946
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Greenlawn, Plattburg, Mo
18. (a) Signature of funeral director H. A. Sullivan
(b) Address Gowen Mo

19. (a) Aug. 2 1946 (b) H. J. Kustelink
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 29th
year 1946 hour 6 minute 55 A.M.

21. I hereby certify that I attended the deceased from 7/24 - 1946 to 7/29 - 1946
that I last saw him alive on 7/28 1946
and that death occurred on the date and hour stated above.

Immediate cause of death. Perforated duodenal ulcer
Duration 5 days

Due to.....
Due to.....

Other conditions. 1170'
(Include pregnancy within 3 months of death)

Major findings: Perforated ulcer of duodenum
Of operations.....
Of autopsy Peritonitis, acute

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)
(c) Means of injury.....

23. Signature G. T. Blowers M.D.
Address 1218 N. 32 St., St. Joseph, Mo. 7/29/46

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

MOTHER FATHER

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.....

H. A. Sullivan

Licensed Embalmer No.....

1738

P. O. Address.....

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