N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

REC'D APR 17 1939

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

9585
Do not use this space.

1. PLACE OF DEATH
(a) County Jackson 2
(b) Township Kaw 1
(c) City K. C. Mo.
Registration District No. 399
Primary Registration District No. 1002
Registered No. 1191
(d) Street No. 4452 Penn St.
(If death occurred in Hospital or Institution, write its name instead of street and number)
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME 453 Mrs. Nancy Ann Billings
(a) Residence, No. 4452 Penn St.
(Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

## PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
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: Bird Franklin Billings

6. DATE OF BIRTH (MONTH, DAY, AND YEAR): August 20, 1852

7. AGE: Years 86 | Months 6 | Days 27 | If LESS than 1 day, ....hrs. or ....min.

OCCUPATION
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.: At Home
9. Industry or business in which work was done, as 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): Adrian County, Mo.

FATHER
13. NAME: Moses Bailey
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): West Virginia

MOTHER
15. MAIDEN NAME: Margaret Peacher
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Missouri

17. INFORMANT: Dr. J. H. Billings
(ADDRESS) 4452 Penn

18. BURIAL, CREMATION, OR REMOVAL
PLACE Butler, Mo. DATE Mar. 19, 1939

19. FUNERAL DIRECTOR (NAME) John W. Wagner
(ADDRESS) Kansas City, Mo.

20. FILED Mar 19, 1939 M. M. Crowe
Local Registrar.

## MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR): March 17, 1939

22. I HEREBY CERTIFY, That I attended deceased from July 15, 1938, to Mar 17, 1939
I last saw him alive on Mar 16, 1939. Death is said to have occurred on the date stated above, at 7:30 m.
The principal cause of death and related causes of importance were as follows:

Cerebral Hemorrhage — Date of onset 7-15-38
9 Yr

Other contributory causes of importance:
Multiple Myelomatosis
Senility

Name of operation ..... Date of .....
What test confirmed diagnosis? Clinical 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? no
If so, specify .....
(Signed) Carl Jackson, M. D.
(Address) 507 Ennis Bldg

(Licensed Embalmer's Statement on Reverse Side)

Dr. Carl Jackson
1103 Earinouth
Commerce Bg

VI 9171

## 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.....

Licensed Embalmer No.....

P. O. Address.....

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

**If this body is not embalmed, above space should be left blank.**