

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

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.

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

20353
Do not use this space.

JUL 12 1939

1. PLACE OF DEATH

(a) County Registration District No. **791**
(b) Township Primary Registration District No. **1008**
(c) City St. Louis (d) Street No. DePaul Hospital 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. da. (f) How long in U. S., if of foreign birth? yrs. mos. da.

2. PRINT FULL NAME

452 Ralph Billingsley, Jr.
(a) Residence, No. 6202A Suburban Ave. St. WR Wellston, Mo.
(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 Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Single

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) May 11, 1934

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
5 0 28

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) Missouri.

FATHER 13. NAME Ralph Billingsley, Sr.

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Missouri. 0

MOTHER 15. MAIDEN NAME Bengta Olson 0

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Missouri. 0

17. INFORMANT (ADDRESS) Ralph Billingsley, Sr.
6202a Suburban Ave.

18. BURIAL, CREMATION, OR REMOVAL PLACE Calvary Cem. DATE June 10/39.

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Jos. W. Clark
1125 Hodiamont Ave.

20. FILED JUN 9 1939 19
J. F. Bredich
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) June 8/39. 19

22. I HEREBY CERTIFY, That I attended deceased from 6-3-39 to 6-8-39, 1939
I last saw him alive on 6-8-39, 1939 Death is said to have occurred on the date stated above, at 12.47 A.M.
The principal cause of death and related causes of importance were as follows:

Typhoid
Date of onset 5-28-39

Other contributory causes of importance:

Name of operation..... Date of.....
What test confirmed diagnosis? Culture of blood 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 4, 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) Ray Johnson, M. D.
(Address) Flanagan, Mo.

Dr. Roy Johnson
Ferguson, Mo.

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..... *Joe W. Clark*.....
Licensed Embalmer No. 1861
P. O. Address 1125 Hodiament Ave.,

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.