S. No. 2
M—8-43
5-17-39
P I X37823

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

613

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED JAN 26 1946

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 2670

Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 7

1. PLACE OF DEATH:

(a) County Greene

(b) City or town Springfield

(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: 904 North, Fremont, 1

(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution ..... (Specify whether

In this community 2 weeks

years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Christian 22

(c) City or town Spokane Mo. 0

(If outside city or town limits, write "RURAL")

(d) Street No. none 0

(If rural, give location)

(e) Citizen of foreign country? no (Yes or No) 1

If yes, name country

3. (a) PRINT FULL NAME Mae Billingsly

3. (b) If veteran, name war None

3. (c) Social Security No. None

4. Sex Female 1

5. Color or race White

6. (a) Single, widowed, married, divorced Married 1

6. (b) Name of husband or wife Robert W. Billingsly

6. (c) Age of husband or wife if alive 58 years

7. Birth date of deceased Nov. (Month) 5 (Day) 1883 (Year)

8. AGE: Years 62 Months 1 Days 28 If less than one day ..... hr. ..... min.

9. Birthplace Lawrence (City, town, or county) Kansas 1 (State or foreign country)

10. Usual occupation House wife

11. Industry or business

FATHER
12. Name John Pryor
13. Birthplace UNK. (City, town, or county) Penn. 1 (State or foreign country)

MOTHER
14. Maiden name Sarah Wilkerson
15. Birthplace UNK. (City, town, or county) Kansas 1 (State or foreign country)

16. (a) Informant Robert W. Billingsly

(b) Address Spokane, Mo. 0

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 6-46 (Month) (Day) (Year)

(c) Place: burial or cremation Spokane Cemetery

18. (a) Signature of funeral director T. B. Chaffin

(b) Address Ozark Mo.

19. (a) 1-8-46 (Date received local registrar) (b) S. W. Housley (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan. day 3 year 1946 hour 9 minute 25 P.M.

21. I hereby certify that I attended the deceased from Dec 21, 1945, to Jan 1, 1946 that I last saw her alive on ~~Jan 1~~ Jan 1, 1946 and that death occurred on the date and hour stated above.

Immediate cause of death Cardiac Occlusion

Due to Pulmonary Cremation

Due to Metastasis

Other conditions (Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy 94

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? (Specify type of place)

While at work? (e) Means of injury

23. Signature E. C. Haberer (M. D. or other) ✓

Address Springfield Mo. Date signed 1-8-46

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(Licensed Embalmer's Statement on Reverse Side)

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 T. B. Chaffin

Licensed Embalmer No. 2152

P. O. Address Ozark 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.