

S. No. 2
M-5-43
7-5-17-39
P I X36671

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

21539

State File No.

FILED JUL 3 1946
318

1003

Registrar's No.

5563

Registration District No.

Primary Registration District No.

1. PLACE OF DEATH:

(a) County.....
(b) City or town..... St. Louis, Mo.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
St. John's Hosp. O
(If not in hospital or institution, write street number and location)
(d) Length of stay: In hospital or institution.....
(Specify whether
In this community..... 1 day 6 hr. 40 min.
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State..... Mo. (b) County..... 000
(c) City or town..... St. Louis 617
(If outside city or town limits, write "RURAL")
(d) Street No. 5322 Northland 9
(If rural, give location)
(e) Citizen of foreign country?..... (Yes or No)
If yes, name country.....

3. (a) PRINT FULL NAME MONIEA MARY BILLINGS
3. (b) If veteran, name war..... 3. (c) Social Security No.....

4. Sex..... FEMALE 5. Color or race..... White
6. (a) Single, widowed, married, divorced..... 0
6. (b) Name of husband or wife..... 6. (c) Age of husband or wife if alive..... years
7. Birth date of deceased..... 6 / 21 / 46
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
6 hr. 40 min.

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

10. Usual occupation.....

11. Industry or business.....

MOTHER FATHER { 12. Name Charles Patrick Billings
13. Birthplace St. Louis, Missouri
(City, town, or county) (State or foreign country)
14. Maiden name Mary Ellen Nixon
15. Birthplace Sedalia, Missouri
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Charles Billings
(b) Address 5322 Northland

17. (a) Burial (b) Date thereof 6/24/46
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Calvary Cemetery

18. (a) Signature of funeral director Joseph H. Howard
(b) Address 1619 Grand

19. (a) JUN 24 1946 (b) J. F. Bredeek
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month..... 6 day..... 22
year..... 1946 hour..... 12 minute..... 45 P.M.
21. I hereby certify that I attended the deceased from June 21
..... 1946, to June 22, 1946
that I last saw her alive on June 22, 1946
and that death occurred on the date and hour stated above.

Immediate cause of death..... Duration

Atelactasis
Due to Prematurity 6 mos gestation
Due to Premature separation of placenta
Other conditions..... (Include pregnancy within 3 months of death)

PHYSICIAN
Major findings:
Of operations.....
Of autopsy.....
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)
(e) Means of injury.....

23. Signature Matthew W. Wine (M. D. or other) MD
Address 634 No. Grand, ave. Date signed 6/29/46

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.....

James A. Howard

Licensed Embalmer No. *4139*

P. O. Address. *4212 St Louis 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, fact should be so stated above.