S. No. 2
M—8-43
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

29991

State File No.

FILED SEP 23 1946

Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 723

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: Burge Hosp. 0
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 3 days (Specify whether
In this community years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Greene 39
(c) City or town Fair Grove 0
(If outside city or town limits, write "RURAL")
(d) Street No. Route #1 0
(If rural, give location)
(e) Citizen of foreign country? no. (Yes or No) 1
If yes, name country

3. (a) PRINT FULL NAME William Henry Billings
3. (b) If veteran, name war None
3. (c) Social Security No. None
4. Sex male
5. Color or race White
6. (a) Single, widowed, married, divorced single
6. (b) Name of husband or wife None
6. (c) Age of husband or wife if alive XX years
7. Birth date of deceased March (Month) 8 (Day) 1931 (Year)

8. AGE: Years 15 Months 5 Days 23 If less than one day hr. min.
9. Birthplace Kansas City (City, town, or county) Kansas (State or foreign country)
10. Usual occupation Student
11. Industry or business
FATHER
12. Name William Henry Billings
13. Birthplace Atchison (City, town, or county) Kansas (State or foreign country)
MOTHER
14. Maiden name Judith Eleanor Williams
15. Birthplace Springfield (City, town, or county) Missouri (State or foreign country)
16. (a) Informant Mrs Cynthia Bondgien
(b) Address Fair grove, Missouri
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/4/1946 (Month) (Day) (Year)
(c) Place: burial or cremation EAST LAWN CEMETERY
18. (a) Signature of funeral director ALMA LOHMEYER FUNERAL HOME
(b) Address SPRINGFIELD, MISSOURI
19. (a) 9-9-46 (Date received local registrar) (b) Dr W E Hardy M.D. (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept 1 day 1
year 1946 hour 9 hr minute 38 p.M.
21. I hereby certify that I attended the deceased from Aug-29-1946 to Sept-1-1946
that I last saw him alive on Sept-1-1946
and that death occurred on the date and hour stated above.

Immediate cause of death Codema of lungs
Due to Paralysis
Due to Gun Shot wound
Other conditions (Include pregnancy within 3 months of death)
Major findings:
Of operations
Of autopsy

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

184.8
17

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) accident 39
(b) Date of occurrence Aug-29-46
(c) Where did injury occur? Fair Grove, Mo (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? In farm (Specify type of place)
While at work? no (e) Means of injury Shot gun
23. Signature Henry Knapp (M. D. or other)
Address 450½ E Court, Sp. Mo. Date signed 9/9/46

28827

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

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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 Frank Gable

Licensed Embalmer No. 4140

P. O. Address Springfield, 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.