

FILED AUG 11 1948

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 25170

Registration District No. 370

Primary Registration District No. 6151

Registrar's No. 49

1. PLACE OF DEATH:

(a) County **Stoddard**

(b) City or town **Parma Rt. 1**
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: **1**

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

(d) Length of stay: **25 years**
In this hospital or institution. (Specify whether years, months or days)

In this community: **25 years**
years, months or days

3. (a) PRINT FULL NAME **Tom Billops**

3. (b) If veteran, name war: **None**

3. (c) Social Security No. _____

4. Sex: **M**

5. Color or race: **Negro**

6. (a) Single, widowed, married, divorced: **Widowed**

6. (b) Name of husband or wife _____

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

7. Birth date of deceased: **FEBRUARY 22 1893**
(Month) (Day) (Year)

8. AGE: Years **55** Months **4** Days **26**

If less than one day: _____ hr. _____ min.

9. Birthplace: **Arkansas**
(City, town, or county) (State or foreign country)

10. Usual occupation: **Farmer**

11. Industry or business _____

12. Name: **Unknown**

13. Birthplace: **Unknown**
(City, town, or county) (State or foreign country)

14. Maiden name: **Unknown**

15. Birthplace: **Unknown**
(City, town, or county) (State or foreign country)

16. (a) Informant: **Tomies Billops**(b) Address: **Parma Rt. 1**

17. (a) **Burial** (b) Date thereof: **July 21/48**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation: **Broadwater**

18. (a) Signature of funeral director: **Walter J. Funeral Service**
(b) Address: **Parma, Mo**

19. (a) **8-3-48** (b) **Walter J. Funeral Service**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State: **Missouri** (b) County: **Stoddard**

(c) City or town: **Parma rt. 1**
(If outside city or town limits, write "RURAL")

(d) Street No.: **3 mi East of Hillsboro**
(If rural, give location)

(e) Citizen of foreign country: **No** (Yes or No)

If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **July** day **18**
year **1948** hour **14** minute **300** M.

21. I hereby certify that I attended the deceased from **7-18-48**, 19____ to **7-18-48**, 19____;
that I last saw him alive on **7-18-48**, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death: _____ Duration _____

Crown Thrombosis

Due to: _____

Due to: _____

Other conditions: _____
(Include pregnancy within 3 months of death)

Major findings: _____

Of operations: _____

Of autopsy: _____

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? _____

(a) Signature: **W. J. [Signature]** (Specify type of place) _____
(b) Address: **Parma, Mo** (c) Means of injury: **2**

23. Signature: **W. J. [Signature]** (M. D. or other) _____Address: **Parma, Mo** Date signed: **7-21-48**

RECEIVED

District Health Office

District File Number *848-1*

Date Filed *8-9*

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 *Lyman Steele*

Licensed Embalmer No. *2476*

P. O. Address *Dexter 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.