

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 27869
1222

FILED AUG 27 1949

BIRTH NO. _____		REG. DIST. NO. <u>318</u>		PRIMARY REG. DIST. NO. <u>1003</u>		Registrar's No. _____			
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Mo</u> b. COUNTY _____					
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St Louis</u>		c. LENGTH OF STAY (In this place) _____		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Union</u>		d. STREET ADDRESS (If rural, give location) <u>U R =</u>			
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>St Anthony's Hospital</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>8-13-1949</u>					
3. NAME OF DECEASED (Type or Print) <u>Harold</u>		a. (First) _____		b. (Middle) <u>Billings Jr</u>		c. (Last) _____			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>married</u>		8. DATE OF BIRTH <u>4-1-1924</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SALESMAN</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Appliances</u>		11. BIRTHPLACE (State or foreign country) <u>New York</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13a. FATHER'S NAME <u>Harold Billings Sr</u>		13b. MOTHER'S MAIDEN NAME <u>Josephine Towne</u>		14. NAME OF HUSBAND OR WIFE <u>Dorothy</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) _____		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>105-18-5718</u>		17. INFORMANT'S SIGNATURE OR NAME <u>Dorothy Billings</u> ADDRESS <u>Union Mo</u>					
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.				MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH: <u>Pseudotub. Poliomylidosis</u> <u>Spinal Paralytic (Encephalitic) Bulbar</u> ANTECEDENT CAUSES _____ Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. _____ DUE TO (b) _____ DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. _____				INTERVAL BETWEEN ONSET AND DEATH <u>10 days</u>	
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT SUICIDE HOMICIDE (Specify) _____		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <u>Union Mo</u>					
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>0800</u>					
22. I hereby certify that I attended the deceased from <u>8-8</u> , 19 <u>49</u> , to <u>8-13</u> , 19 <u>49</u> , that I last saw the deceased alive on _____, 19____, and that death occurred at <u>1017 A.</u> , from the causes and on the date stated above.									
23a. SIGNATURE (Degree or title) <u>Murphy (MD)</u>				23b. ADDRESS <u>St. Charles Hosp.</u>		23c. DATE SIGNED <u>8-14-49</u>			
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24b. DATE <u>8-13-49</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Union</u>		24d. LOCATION (City, town, or county) (State) <u>Mo</u>			
DATE REC'D BY LOCAL REG. <u>AUG 19 1949</u>		REGISTRAR'S SIGNATURE <u>J. B. Lasater</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Rowland Mortuary Service, Inc.</u> ADDRESS _____					

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

AUG 30 1949

JUL 11 1952

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 _____

Student Embalmer No. _____

working under my personal supervision.

Signed _____

Ronald Dyaburke

Signed _____

Student Embalmer

Licensed Embalmer No. 3917

P. O. Address. St. Louis 10 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.