

Health, & Welfare  
Public  
Service

FILED NOV 13 1957

STANDARD CERTIFICATE OF DEATH

35402

STATE FILE NUMBER

Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 1037C

300  
1-57

1. PLACE OF DEATH a. COUNTY <b>Greene</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Greene</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Springfield</b>		c. CITY OR TOWN <b>Springfield</b>	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>St John's Hospital</b>		Length of stay in 1b <b>50 yrs</b>	
d. STREET ADDRESS <b>1666 E. Grand</b>		(If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>ERMA L. (SMITH) BILLINGS</b>			4. DATE OF DEATH Month Day Year <b>October 24, 1957</b>
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 30, 1887</b>
9. AGE (In years last birthday) <b>70</b>		10. F UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	11. BIRTHPLACE (City and state or country) <b>St Louis, Missouri</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13a. FATHER'S NAME <b>William C. Smith</b>	
13b. MOTHER'S MAIDEN NAME <b>Margaret (unknown)</b>		14. NAME OF HUSBAND OR WIFE <b>MISSIX</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>	
17. INFORMANT <b>Henry D. Billings, Springfield, Mo.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CEREBRAL HEMORRHAGE, RIGHT MIDDLE CEREBRAL ARTERY</b>			INTERVAL BETWEEN ONSET AND DEATH <b>2 DAYS</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>HYPERTENSIVE CARDIOVASCULAR DISEASE</b>			
DUE TO (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) - - - <b>443X</b>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.			
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>(207)</b>	
20f. CITY, TOWN, OR LOCATION <b>Springfield</b>		COUNTY STATE	
21. I attended the deceased from <b>10/24/57</b> to <b>10/24/57</b> and last saw him <b>live</b> on <b>10/24/57</b> . Death occurred at <b>11:20 p.m.</b> on the date stated above; and to the best of my knowledge, from the causes stated.			
22. SIGNATURE <b>Shem O. Turner, M.D.</b>		22b. ADDRESS <b>Springfield Mo.</b>	
22c. DATE SIGNED <b>10/31/57</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>Oct 28, 1957</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Maple Park Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Springfield, Missouri</b>	
24. FUNERAL DIRECTOR <b>Jewell E. Winkle</b>		ADDRESS <b>Springfield, Mo.</b>	
25. DATE RECD. BY LOCAL REG. <b>11-4-57</b>		26. REGISTRAR'S SIGNATURE <b>Earl Williamson</b>	

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

NOV 13 1957

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.

Student .....  
Signature of Student Embalmer

Signed *Robert E. Muhlman*

Licensed Embalmer No. *4916*

P. O. Address *Springfield*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.