

DEPARTMENT OF HEALTH - STANDARD CERTIFICATE OF DEATH

60-019900

FILED VS MAY 23 1960

Registration District No. 164 Primary Registration District No. 3032 Registrar's No. 66

STATE FILE NUMBER

UNDE

1. PLACE OF DEATH a. COUNTY <u>Johnson</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Johnson</u>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Warrensburg</u>		Length of stay in 1b <u>18 days</u>	c. CITY OR TOWN <u>Warrensburg</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
c. FULL NAME OF HOSPITAL OR INSTITUTION <u>Warrensburg Medical Center</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>517 Maple</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <u>Alvia</u> Middle <u>Robert</u> Last <u>Billingsley</u>			4. DATE OF DEATH Month <u>May</u> Day <u>20</u> Year <u>1960</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>June 9/1876</u>	9. AGE (last birthday) <u>83</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>	11. BIRTHPLACE (City and state or country) <u>Davis Co. Mo.</u>	12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13a. FATHER'S NAME <u>George Billingsley</u>		13b. MOTHER'S MAIDEN NAME		14. NAME OF HUSBAND OR WIFE <u>Annie Mapes (Ded)</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO.	17. INFORMANT <u>Mrs Irene Griffey Warrensburg, Mo.</u> Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:				INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (a) <u>Hypostatic pneumonia</u>				<u>7 days</u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Fracture of left femur</u>				<u>18 days</u>	
DUE TO (c) <u>Generalized arteriosclerosis</u>				<u>18 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)				PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input checked="" 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.) <u>Fell on bath room floor.</u>			
20c. TIME OF INJURY <u>9:00 p.m.</u>	Month, Day, Year <u>5-2-60</u>				
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>His home 517 Maple</u>	20f. CITY, TOWN, OR LOCATION <u>Warrensburg</u>	COUNTY <u>Johnson</u>	STATE <u>Mo</u>	
21. I attended the deceased from <u>5-2-60</u> , to <u>5-20-60</u> and last saw him alive on <u>5-20-60</u> . Death occurred on _____ m on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <u>[Signature]</u> (Degree or title) <u>M.D.</u>			22b. ADDRESS <u>Warrensburg, Missouri</u>		22c. DATE SIGNED <u>5-21-60</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>5/22/1960</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Sunset Hill</u>	23d. LOCATION (City, town, or county) (State) <u>Warrensburg, Missouri</u>		
24. FUNERAL DIRECTOR <u>Sweeney-Phillips Warrensburg, Mo.</u> ADDRESS		25. DATE RECD. BY LOCAL REG. <u>5-21-60</u>	26. REGISTRAR'S SIGNATURE <u>[Signature]</u>		

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

Earliest Report

STATEMENT BY LICENSED EMBALMER

0961

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed

Mavis O'Sullivan

Licensed Embalmer No. *4887*

P. O. Address *Warrington*

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.