

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

PLACE OF DEATH

County Wayne
 Township Williams
 or
 Village _____
 or
 City _____ (NO. _____ St. _____ Ward _____)

 MISSOURI STATE BOARD OF HEALTH
 BUREAU OF VITAL STATISTICS
 CERTIFICATE OF DEATH

31372

Registration District No. 892 File No. _____
 Primary Registration District No. 6193 Registered No. 79

[If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME

Walter Hollis Bilbey

PERSONAL AND STATISTICAL PARTICULARS

SEX <u>Male</u>	COLOR OR RACE <u>White</u>	SINGLE MARRIED WIDOWED OR DIVORCED (Write the word)
DATE OF BIRTH <u>Sept. 4</u> , 191 <u>8</u> (Month) (Day) (Year)		
AGE ____ yrs. ____ mos. <u>6</u> ds.		If LESS than 1 day, ____ hrs. or ____ min.?
OCCUPATION (a) Trade, profession, or particular kind of work <u>V</u> (b) General nature of industry, business, or establishment in which employed (or employer) <u>V</u>		
BIRTHPLACE (City or town, State or foreign country) <u>Williams Twp.</u>		
PARENTS	NAME OF FATHER <u>Walter Bilbey</u>	
	BIRTHPLACE OF FATHER <u>Wayne Co. Mo.</u>	
	MAIDEN NAME OF MOTHER <u>Hattie Wells</u>	
	BIRTHPLACE OF MOTHER <u>Iron Co. Mo.</u>	

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Walter Bilbey
 (ADDRESS) Williams Twp. Mo.
 Filed Sept 10, 1918, J. L. McShu
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Sept. 10, 1918
 (Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from

_____, 191____, to _____, 191____,

that I last saw h. _____ alive on _____, 191____,

and that death occurred, on the date stated above, at _____ m.

The CAUSE OF DEATH* was as follows:

Bold Thies family thought
had no physician
200A

(Duration) _____ yrs. ____ mos. ____ ds.

Contributory

(SECONDARY)

(Duration) _____ yrs. ____ mos. ____ ds.

(Signed) Walter Bilbey (father)
Sept 10, 1918 (Address) Williams Twp. Mo.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death _____ yrs. ____ mos. ____ ds. In the State _____ yrs. ____ mos. ____ ds.

Where was disease contracted
 if not at place of death?

Former or
 usual residence _____

PLACE OF BURIAL OR REMOVAL

Black River

UNDERTAKER

none

DATE OF BURIAL

Sept 11, 1918

ADDRESS

PLACE OF DEATH

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

County _____

Township _____
or _____

Village _____

City _____

(NO. _____)

Registration District No. _____

Primary Registration District No. _____

File No. _____

Registered No. _____

St. _____

[If death occurred in a
hospital or institution,
give its NAME instead
of street and number]

FULL NAME

PERSONAL AND STATISTICAL PARTICULARS

SEX _____
COLOR OR RACE _____
SINGLE
MARRIED
WIDOWED
OR DIVORCED
(If rite the word)DATE OF BIRTH _____
(Month) _____ (Day) _____ (Year) _____AGE _____
IF LESS than
1 day, _____ hrs.
or _____ min.?OCCUPATION _____
(a) Trade, profession, or
particular kind of work
(b) General nature of industry,
business, or establishment in
which employed (or employer)BIRTHPLACE _____
(City or town,
State or foreign country)

NAME OF FATHER _____

BIRTHPLACE OF FATHER _____
(City or town, State or foreign country)

MAIDEN NAME OF MOTHER _____

BIRTHPLACE OF MOTHER _____
(City or town, State or foreign country)

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) _____

(ADDRESS) _____

Filed _____ 191 _____

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH _____
(Month) _____ (Day) _____ (Year) _____I HEREBY CERTIFY, that I attended deceased from
_____, 191____, to _____, 191____,
that I last saw h_____ alive on _____, 191____,
and that death occurred, on the date stated above, at _____ m.
The CAUSE OF DEATH* was as follows:

(Duration) _____ yrs. _____ mos. _____ ds.

Contributory
(SECONDARY)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) _____ 191____ (Address) _____ M. D. _____

*State the Disease Causing Death, or, in deaths from Violent Causes, state
(1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR
RECENT RESIDENTS)At place of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.
Where was disease contracted if not at place of death?

Former or usual residence _____

PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

UNDERTAKER

ADDRESS

191____