

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.

**BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH**

6659

1. PLACE OF DEATH *Polk*  
 County *Polk* Registration District No. *710*  
 Township *Mooney* Primary Registration District No. *5939*  
 City *Mooney* (No. ....) St. .... Ward ....

2. FULL NAME *Manning Douglas Bills*  
 (a) Residence. No. .... St. .... Ward ....  
 (Usual place of abode) (If nonresident give city or town and State)  
 Length of residence in city or town where death occurred yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da.

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX *M* 4. COLOR OF RACE *White* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) *Widower*

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF *Cynthia Hulbert*

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *April 26 - 1857*

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, ... hrs. or ... min.
	<i>73</i>	<i>9</i>	<i>21</i>	

8. OCCUPATION OF DECEASED  
 (a) Trade, profession, or particular kind of work *Farmer 1*  
 (b) General nature of industry, business, or establishment in which employed (or employer)  
 (c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) *Missouri 1*  
 (STATE OR COUNTRY)

10. NAME OF FATHER *Alfred Bills*

11. BIRTHPLACE OF FATHER (CITY OR TOWN) *Missouri*  
 (STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER *Martha McClinton*

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) *Missouri*  
 (STATE OR COUNTRY)

14. INFORMANT *M Bills*  
 (Address) *1702 W Chase St*

15. FILED *Feb 21 1931* *Springfield Mo*  
*Estelle Benton*  
 REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) *Feb 17<sup>th</sup> 1931*

17. I HEREBY CERTIFY, That I attended deceased from *2-2* 1931 to *2-17* 1931 that I last saw him alive on *2-17* 1931 and that death occurred, on the date stated above, at *9:30 a.m.*

THE CAUSE OF DEATH\* WAS AS FOLLOWS:  
*Paralysis*  
*old age* (duration) yrs. mos. da.

CONTRIBUTORY (SECONDARY) *old age* (duration) yrs. mos. da.

18. WHERE WAS DISEASE CONTRACTED *Home*  
 IF NOT AT PLACE OF DEATH: .....

DID AN OPERATION PRECEDE DEATH: .....

19. WAS THERE AN AUTOPSY? *no*

WHAT TEST CONFIRMED DIAGNOSIS *W.C. Allbright*, M. D.  
*2-17 1931* (Address) *Pleasant Hope Mo*

\*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL *Greenlawn Spg Mo* DATE OF BURIAL *Feb 19 1931*

20. UNDERTAKER *W.L. Starone* ADDRESS *Springfield Mo*  
*Walnut & Market*



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

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

**1. PLACE OF DEATH**

County Frank Registration District No. 410  
Township Mooney Primary Registration District No. 5-939  
City (No. \_\_\_\_\_) \_\_\_\_\_ St. \_\_\_\_\_ Ward \_\_\_\_\_

File No. \_\_\_\_\_  
Registered No. \_\_\_\_\_

**2. FULL NAME**

(a) Residence, No. \_\_\_\_\_ St. \_\_\_\_\_ Ward \_\_\_\_\_

(Usual place of abode) \_\_\_\_\_ (If nonresident, give city or town and State)  
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) wid

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF \_\_\_\_\_

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) \_\_\_\_\_

7. AGE YEARS MONTHS DAYS If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.

OCCUPATION 8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. \_\_\_\_\_

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. \_\_\_\_\_

10. Date deceased last worked at this occupation (month and year) \_\_\_\_\_

11. Total time (years) spent in this occupation \_\_\_\_\_

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) \_\_\_\_\_

FATHER 13. NAME \_\_\_\_\_

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) \_\_\_\_\_

MOTHER 15. MAIDEN NAME \_\_\_\_\_

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) \_\_\_\_\_

17. INFORMANT (ADDRESS) \_\_\_\_\_

18. BURIAL, CREMATION, OR REMOVAL PLACE \_\_\_\_\_ DATE \_\_\_\_\_ 19

19. UNDERTAKER (ADDRESS) \_\_\_\_\_

20. FILED Feb 21 1931 Estelle Benton Registrar.

**MEDICAL CERTIFICATE OF DEATH**

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Feb 17 1931

22. I HEREBY CERTIFY, That I attended deceased from \_\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_

I last saw him alive on \_\_\_\_\_, 19\_\_\_\_. Death is said to have occurred on the date stated above, at \_\_\_\_\_ m.

The principal cause of death and related causes of importance were as follows: \_\_\_\_\_ Date of onset \_\_\_\_\_

Paralysis of Right side  
Decubite Paralysis

Other contributory causes of importance: Old age

Name of operation \_\_\_\_\_ Date of \_\_\_\_\_  
What test confirmed diagnosis? \_\_\_\_\_ Was there an autopsy? \_\_\_\_\_

23. If death was due to external causes (violence), fill in also the following: Accident, suicide, or homicide? \_\_\_\_\_ Date of injury \_\_\_\_\_, 19\_\_\_\_

Where did injury occur? \_\_\_\_\_ (Specify city or town, county, and State)  
Specify whether injury occurred in industry, in home, or in public place. \_\_\_\_\_

Manner of injury \_\_\_\_\_  
Nature of injury \_\_\_\_\_

24. Was disease or injury in any way related to occupation of deceased? \_\_\_\_\_  
If so, specify \_\_\_\_\_  
(Signed) \_\_\_\_\_, M. D.  
(Address) \_\_\_\_\_

SUPPLEMENTARY

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. REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

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