

Registration District No. 172

Primary Registration District No. 5239

1. PLACE OF DEATH: Chariton

(a) County Rural Saltcreek

(b) City or town (If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: -

(If not in hospital or institution, write street number or location) 2

(d) Length of stay: In hospital or institution (Specify whether)

In this community (Specify whether)
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Chariton

(c) City or town Rural
(If outside city or town limits, write "RURAL")

(d) Street No. (If rural, give location)

(e) If foreign born, how long in U. S. A. years

3. (a) PRINT FULL NAME Wayne Everett Billups 4:7

3. (b) If veteran, name war (Specify whether)

3. (c) Social Security No. (Specify whether)

4. Sex M

5. Color or race W

6. (a) Single, widowed, married, divorced single

6. (b) Name of husband or wife (Specify whether)

6. (c) Age of husband or wife If alive 11 years 1930

7. Birth date of deceased March 11 1930
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>10</u>	<u>2</u>	<u>4</u>	<u>hr. min.</u>

9. Birthplace Near Mendon Mo.
(City, town, or county) (State or foreign country)

10. Usual occupation School Boy

11. Industry or business (Specify whether)

MOTHER FATHER

12. Name Everett Billups

13. Birthplace near Mendon Mo
(City, town, or county) (State or foreign country)

14. Maiden name Helen Hedrick

15. Birthplace Wayne Co Mo.
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Mrs. Everett Billups

(b) Address Mendon Mo

17. (a) Burial (b) Date thereof 5/17/1940
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Powell Cemetery

18. (a) Signature of funeral director S. J. Shepard

(b) Address Mendon Mo

19. (a) 5/16/40 (b) W. W. West
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 15
year 1940 hour 9 minute 30 P.M.

21. I hereby certify that I attended the deceased from May 1st
1940 to May 15 1940
that I last saw him alive on May 14 1940
and that death occurred on the date and hour stated above.

Immediate cause of death Meningitis following Ear infection

Due to (Specify whether)

Due to (Specify whether)

Other conditions 0
(Include pregnancy within 3 months of death)

PHYSICIAN

Major findings:
Of operations 0

Of autopsy 0

Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) (Specify type of place)

(b) Date of occurrence (Specify type of place)

(c) Where did injury occur? (Specify type of place)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? 11:00
While at work? (Specify type of place)

23. Signature W. B. Lucas (M. D. or other)

Address Mendon Mo Date signed (Specify whether)

MARGIN RESERVED FOR BINDING

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

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.

RECEIVED
District Health Officer No. 8
District File Number
Date Filed 7-3-40

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 7112

....., Registered Apprentice No.
working under my personal supervision.

Signed A. S. Leppard

Licensed Embalmer No. 3976

P. O. Address Wendover 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, above space should be left blank.