

Registration District No. 184 Primary Registration District No. 6270

1. PLACE OF DEATH:  
(a) County Christian  
(b) City or town Spokane Mo  
(c) Name of hospital or institution:  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether)  
In this community 65 71 years, months or days

3. (a) PRINT FULL NAME John H. Billingsley  
3. (b) If veteran \_\_\_\_\_ name war \_\_\_\_\_  
3. (c) Social Security No. \_\_\_\_\_

4. Sex Male 5. Color or race W  
6. (a) Single, widowed, married, divorced Married  
6. (b) Name of husband or wife are Billingsley  
6. (c) Age of husband or wife if alive 78 years  
7. Birth date of deceased Nov 1 1856  
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>83</u>	<u>10</u>	<u>7</u>	hr. _____ min. _____

9. Birthplace Missouri  
(City, town, or county) (State or foreign country)

10. Usual occupation Farmer

11. Industry or business \_\_\_\_\_

MOTHER FATHER { 12. Name Don't know  
18. Birthplace Don't know  
(City, town, or county) (State or foreign country)

MOTHER FATHER { 14. Maiden name Don't know  
15. Birthplace Don't know  
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Robert W. Billingsley  
(b) Address Spokane Mo

17. (a) Buried (Burial, cremation, or removal) (b) Date thereof Oct 9 1940  
(Month) (Day) (Year)

(c) Place: burial or cremation Spokane Mo

18. (a) Signature of funeral director G. B. Chaffin  
(b) Address Ozark Mo

19. (a) Nov 8 1940 (Date received local registrar) (b) Janetta Leonard (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:  
(a) State Mo (b) County Christian  
(c) City or town Spokane Mo  
(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.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 8  
year 1940 hour 3 minute 15 P. M.  
21. I hereby certify that I attended the deceased from Sept 15, 1940, to Oct 8, 1940  
that I last saw him alive on Oct 1, 1940  
and that death occurred on the date and hour stated above.

Immediate cause of death Bacillary Dysentery  
Duration 23 days

Due to \_\_\_\_\_  
Due to \_\_\_\_\_

Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

Major findings: Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

22. If death was due to external causes, fill in the following:  
(a) Accident, suicide, or homicide (specify) \_\_\_\_\_

(b) Date of occurrence \_\_\_\_\_

(c) Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?  
170 (Specify type of place) While at work? (e) Means of injury \_\_\_\_\_

23. Signature R. R. Festinger (M. D. or other) \_\_\_\_\_  
Address Ozark Mo Date signed Nov 7 1940

PHYSICIAN  
Underline the cause to which death should be charged statistically

MAKE PERMANENT—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD  
 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.

RECEIVED

District Health Officer No. 6<sub>r</sub>

District File Number 1140-2903

Date Filed NOV 19 1940

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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.....

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

Signed T. B. Chaffin

Licensed Embalmer No. 2192

P. O. Address Ozark, 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.