

2
-41
-39
228390

FILED AUG 29 1941

State File No. _____

Registrar's District No. _____

Primary Registration District No. _____

Registrar's No. 215

1. PLACE OF DEATH: Adair

(a) County: Adair

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

(c) Name of hospital or institution: Community Nursing Home
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution. _____
(Specify whether years, months or days)

In this community _____
years, months or days

2. USUAL RESIDENCE OF DECEASED: Missouri Macon 61

(a) State: Missouri (b) County: Macon

(c) City or town: La Plata
(If outside city or town limits, write "RURAL")

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

(e) Citizen of foreign country? 1 (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME: William Henry Billings

(b) If veteran, name war: No

(c) Social Security No: NO

4. Sex: M O

5. Color or race: Wh

6. (a) Single, widowed, married, divorced: Widowed

(b) Name of husband or wife: Cora Trout Billings

(c) Age of husband or wife if alive: No years

7. Birth date of deceased: Aug. 27 1860
(Month) (Day) (Year)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 22
year 1941 hour 5 minute 26 P.M.

21. I hereby certify that I attended the deceased from July 6, 1941, to July 22, 1941, that I last saw him alive on July 22, 1941, and that death occurred on the date and hour stated above.

8. AGE: Years 80 Months 10 Days 25 If less than one day hr. _____ min. _____

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

10. Usual occupation: Farmer Ret. Farmer

Immediate cause of death: Respiratory Failure

Due to: Generalized toxemia of Carcinoma of stomach

Due to: Carcinoma of liver

Other conditions: Bright's Disease
(Include pregnancy within 3 months of death)

MOTHER FATHER { 11. Industry or business: Ret. Farmer

12. Name: George W. Billings

13. Birthplace: Ill
(City, town, or county) (State or foreign country)

14. Maiden name: Martha Ann Easley

15. Birthplace: Ill
(City, town, or county) (State or foreign country)

16. (a) Informant: Delmar L. Billings
Address: 215 N. Franklin Kirksville, Mo

17. (a) Burial (b) Date thereof: July 24/41
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation: La Plata, Mo

18. (a) Signature of funeral director: E. Estropfer
Clarence, Mo

(b) Address: _____

19. (a) July 23/41 (b) Spencer L. Freeman
(Date received local registrar) (Registrar's signature)

Major findings: Of operations: none

Of autopsy: none

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? _____
(Specify type of place)

While at work? _____ (e) Means of injury _____

23. Signature: M. T. Hester
Address: Kirksville, Mo Date signed: July 22, 1941

Duration _____

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

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

RECEIVED

District Health Officer No. 10

District File Number 8-41-1577

Date Filed AUG 21 1941

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.....

Licensed Embalmer No.....

P. O. Address.....

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, fact should be so stated above.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 27621
Registrar's No. 215

Registration District No. 1 Primary Registration District No. 1

1. PLACE OF DEATH:

(a) County Adair
(b) City or town Kirkleville
(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)
(d) Length of stay: In hospital or institution _____
(Specify whether _____)
In this community _____
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____
(c) City or town _____
(If outside city or town limits, write "RURAL")
(d) Street No. _____
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME William H. Billing
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex m 5. Color or race w 6. (a) Single, widowed, married, divorced wid
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased _____ (Month) _____ (Day) _____ (Year)

8. AGE: Years _____ Months _____ Days _____ If less than one day _____ min.

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER
12. Name _____
13. Birthplace _____ (City, town, or county) _____ (State or foreign country)
14. Maiden name _____
15. Birthplace _____ (City, town, or county) _____ (State or foreign country)

16. (a) Informant _____
(b) Address _____

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

(c) Place: burial or cremation _____
18. (a) Signature of funeral director _____
(b) Address _____

19. (a) _____ (b) _____
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July Day 21 year 1941 hour _____ minute _____ M.
21. I hereby certify that I attended the deceased from _____ 19____; that I first saw him alive on _____ 19____; and that death occurred on the date and hour stated above. Immediate cause of death Respiratory failure Duration _____

Due to Generalized toxemia of Carcinoma of stomach (primary)
Due to Carcinoma of liver (secondary)
Other conditions Braggi's hepatitis
(Include pregnancy within 3 months of death)

Major findings: Of operations _____
Of autopsy 46B
PHYSICIAN _____
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) _____
(b) Date of occurrence _____
(c) Where did injury occur? _____ (City or town) _____ (County) _____ (State)
(b) Did injury occur in or about home, on farm, in industrial place, in public place? _____
(Specify type of place)
While at work? _____ (e) Means of injury _____

23. Signature _____ (M. D. or other) _____
Address _____ Date signed _____

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



