

Registration District No. 383

Primary Registration District No. 3655

1. PLACE OF DEATH:

(a) County Lawrence  
(b) City or town Mt. Vernon  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
Missouri State Sanatorium  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 24 days  
In this community 24 days  
years, months or days (Specify whether)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Penicott  
(c) City or town Steele  
(If outside city or town limits, write "RURAL")  
(d) Street No. 64 N. Walnut  
(If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Miland Baxter Billingsley

3. (b) If veteran, name war No 3. (c) Social Security No. 332-08-6928

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Single

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased July 8th 1915  
(Month) (Day) (Year)

8. AGE: Years 28 Months 7 Days 5 If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

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

10. Usual occupation Cafe Operator

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

12. Name Thomas Jeff. Billingsley

13. Birthplace Grand Chapin Illinois  
(City, town, or county) (State or foreign country)

14. Maiden name Cecelia O'Shea

15. Birthplace Cairo Illinois  
(City, town, or county) (State or foreign country)

16. (a) Informant E. Hoff Michael, Record Clerk

(b) Address Mo. State San. Mt. Vernon, Mo.

17. (a) Removed (b) Date thereof Feb 20 1944  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Cairo, Ill.

18. (a) Signature of funeral director H. D. Fassett

(b) Address Mt. Vernon Mo.

19. (a) 3-25-44 (b) Candy Ruffel  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb. day 20  
year 1944 hour 7:40 minute \_\_\_\_\_ A. M.

21. I hereby certify that I attended the deceased from Jan  
28th 19 44 to Feb. 20 19 44  
that I last saw him alive on Feb. 20 19 44  
and that death occurred on the date and hour stated above.

Immediate cause of death Pulmonary tuberculosis  
Duration abt 2 1/2 yrs

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

Other conditions (Include pregnancy within 3 months of death)  
Acute tonsillitis, Paronychia, Nephritis  
Major findings: Chronic Pulmonary Nephritis

Of autopsy \_\_\_\_\_  
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)  
(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 NO

23. Signature J. F. [unclear] (M. D. or other) MD  
Address Mount Vernon, Mo Date signed 2-20-44

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

RECEIVED

District Health Officer No. 6,

District File Number

344-324

Date Filed

MAR 15 1944

MAR 2 9 1944

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

*Map L. Fossett*

Licensed Embalmer No. *4252*

P. O. Address *MT Vernon W*

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.