

FILED MAY 10 1944
Registration District No. 128

Primary Registration District No. 2000-5465

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

1. PLACE OF DEATH:

(a) County GREENE
(b) City or town Springfield Rural, N. Campbell Twp.
(c) Name of hospital or institution: R. F. D. # 5
(d) Length of stay: In hospital or institution 77 YR.
In this community 77 YR.

3. (a) PRINT FULL NAME CLYDE DANIEL BILLS

3. (b) If veteran, name war NONE 3. (c) Social Security No. NONE

4. Sex MALE 5. Color or race WHITE 6. (a) Single, widowed, married, divorced MARRIED

6. (b) Name of husband or wife HELEN S. BILLS 6. (c) Age of husband or wife if alive 71 years

7. Birth date of deceased JAN. 6, 1867

8. AGE: Years 77 Months 3 Days 17 If less than one day hr. min.

9. Birthplace GREENE CO. MO.

10. Usual occupation RETIRED FARMER

11. Industry or business FARMING

12. Name BLACKSTON H. BILLS

13. Birthplace UNK. TENN.

14. Maiden name ELIZABETH D. BERRY

15. Birthplace UNK. TENN.

16. (a) Informant MRS. Helen Bills

(b) Address R# 5 Springfield. Mo.

17. (a) Burial (b) Date thereof 4-26-44

(c) Place: burial or cremation Green Lawn Cem.

2. USUAL RESIDENCE OF DECEASED:

(a) State MO. (b) County Greene
(c) City or town Rural, N. Campbell Twp.
(d) Street No. R. F. D. # 5
(e) Citizen of foreign country? No.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 23rd
year 1944 hour 2 minute 00 P. M.

21. I hereby certify that I attended the deceased from April 21 1944 to April 23 1944
that I last saw him alive on April 23 1944
and that death occurred on the date and hour stated above.

Immediate cause of death Menstrage from Duodenal Ulcer

Due to _____

Other conditions None
(Include pregnancy within 3 months of death)

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) NO
(b) Date of occurrence _____
(c) Where did injury occur? _____
(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place)
(e) Means of injury _____

23. Signature Clyde S. Williams (M. D. or other) 4/24/44
Address Springfield Mo Date signed _____

Duration 2 Days
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

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.

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