No. 2
—2-43
5-17-39
I X35697

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 33732

FILED OCT 19 1944

Registrar's Registration District No. _____ Primary Registration District No. 2007 Registrar's No. 330

1. PLACE OF DEATH:
(a) County: Butler
(b) City or town: Poplar Bluff
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Poplar Bluff Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 1 DAY (Specify whether years, months or days)
In this community

2. USUAL RESIDENCE OF DECEASED:
(a) State: Missouri (b) County: Wayne 111
(c) City or town: Williamsville
(If outside city or town limits, write "RURAL") O
(d) Street No. O
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME: Roy Thomas Bilbrey
3. (b) If veteran, name war: —
3. (c) Social Security No. 497-01-8911
4. Sex: Male
5. Color or race: White
6. (a) Single, widowed, married, divorced: Married
6. (b) Name of husband or wife: Mildred Pauline
6. (c) Age of husband or wife if alive: 38 years
7. Birth date of deceased: Aug. (Month) 14 (Day) 1898 (Year)

8. AGE: Years 46 Months 1 Days 26 If less than one day ____ hr. ____ min.

9. Birthplace: Williamsville (City, town, or county) Missouri (State or foreign country)
10. Usual occupation: Laborer
11. Industry or business: Construction
FATHER
12. Name: Squire Bilbrey
13. Birthplace: Tenn. (City, town, or county) (State or foreign country)
MOTHER
14. Maiden name: Gracie Ann Bilbrey
15. Birthplace: Williamsville (City, town, or county) Missouri (State or foreign country)
16. (a) Informant: Mildred Pauline Bilbrey
(b) Address: Williamsville, Mo.
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: OCT. 14, 1944 (Month) (Day) (Year)
(c) Place: burial or cremation: Duncan Cem.
18. (a) Signature of funeral director: Norman W. Gist
(b) Address: Gideon Mo.
19. (a) 10-17-44 (Date received local registrar) (b) Belle Kinnard (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct. day 10 year 1944 hour 7:45 minute P M.
21. I hereby certify that I attended the deceased from 10-10, 1944, to 10-10, 1944; that I last saw alive on 10-10, 1944 and that death occurred on the date and hour stated above.

Duration

Immediate cause of death: Shock on fracture of pelvis, hemorrhage, laceration of liver
Due to: fracture of pelvis, or malignancy
Due to: brain
Other conditions (Include pregnancy within 3 months of death): 1954
Major findings:
Of operations: none 1933
Of autopsy: none

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): Accident
(b) Date of occurrence: 10-10-44
(c) Where did injury occur? Williamsville Mo (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? yes (e) Means of injury
23. Signature: Paul Hamchase (M. D. or other)
Address: Poplar Bluff Mo. Date signed 10-3-44

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(Licensed Embalmer's Statement on Reverse Side)

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

RECEIVED
District Health Office No. 2,
District File Number 1044-1435
Date Filed 12-18-44

APR 3 1947

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. Norman W. Gish

Licensed Embalmer No. 3387

P. O. Address. Piedmont Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wi the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

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21-41
X29288

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No.....

Registration District No. 43 Primary Registration District No. 3007 Registrar's No. 330

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

1. PLACE OF DEATH:

(a) County.....

(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)

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

In this community.....

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 Roy J. Bilbrey

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

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

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

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 ..... hr. ..... 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 Gracie Ann Marler

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

16. (a) Informant.....

(b) Address.....

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

(c) Place: burial or cremation.....

18. (a) Signature of funeral director.....

(b) Address.....

19. (a) 10-17-44 (Date received local registrar) (b) Belle Kinne (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month..... day..... year..... hour..... minute..... M.

21. I hereby certify that I attended the deceased from..... 19..... to..... 19.....; that I last saw h..... alive on..... 19.....; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death.....	
Due to.....	
Due to.....	
Other conditions..... (Include pregnancy within 3 months of death)	

Major findings:
Of operations.....
Of autopsy.....

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.....

SUPPLEMENTARY

RECEIVED
District Health Office No. 2,
District File Number
Date Filed

33792