

FILED APR 9 1945
 Registration District No. **114**

Primary Registration District No. **3035**

Registrar's No. **15**

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

1. PLACE OF DEATH:
 (a) County Lafayette
 (b) City or town Lexington
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: 1218 Franklin
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 40 days (Specify whether years, months or days)

3. (a) PRINT FULL NAME MARGARET V. BILLS

3. (b) If veteran, name war — 3. (c) Social Security No. —

4. Sex Fe 5. Color or race W 6. (a) Single, widowed, married, divorced, married
 6. (b) Name of husband or wife John W. Bills 6. (c) Age of husband or wife if alive 77 years
 7. Birth date of deceased April 8 1967
(Month) (Day) (Year)

8. AGE: Years 77 Months 11 Days 23 If less than one day hr. min.

9. Birthplace Durham, Ont., Canada
(City, town, or county) (State or foreign country)

10. Usual occupation at home

11. Industry or business

MOTHER { 12. Name Wm. D. D. D.
 13. Birthplace Scotland
(City, town, or county) (State or foreign country)
 14. Maiden name Janet Ewen
 15. Birthplace Scotland
(City, town, or county) (State or foreign country)

16. (a) Informant J. W. Bills
 (b) Address Lexington, Mo

17. (a) Burial (b) Date thereof 4-2-45
(Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation Lexington, Mo

18. (a) Signature of funeral director Patrick Schwalbe
 (b) Address Lexington, Mo

19. (a) April 4-45 (b) Mrs. F. Schwalbe
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
 (a) State Mo (b) County Lafayette
 (c) City or town Lexington, Mo
(If outside city or town limits, write "RURAL")
 (d) Street No. 1518 Franklin ?
(If rural, give location)
 (e) Citizen of foreign country? 7 (Yes or No)
 If yes, name country —

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 31
 year 1945 hour 1 minute 21 M.

21. I hereby certify that I attended the deceased from Jan 10 1944 to Mar 31 1945
 that I last saw her alive on Mar 30 1945
 and that death occurred on the date and hour stated above.

Immediate cause of death Heart Disease
dilatation

Due to Chronic Coronary Disease
Myocarditis

Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations 9/2/45
 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?

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

23. Signature W. J. D. D. (M. D. or other)
 Address Lexington, Mo Date signed 3/31/45

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

Plan

RECEIVED

District Health Officer No. 8,

District File Number

Date Filed

4/6/42

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 *J. McLean*.....

..... Licensed Embalmer No. *2983*.....

P. O. Address *Washington 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, fact should be so stated above.