V. S. No. 2
0M—9-4-41
Rev. 5-17-39
I X29484

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED APR 5 1945

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 10995

Registration District No. 3419 Primary Registration District No. 4513 Registrar's No. 2

1. PLACE OF DEATH:
(a) County Sullivan
(b) City or town Green Castle
(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) 1
(d) Length of stay: In hospital or institution (Specify whether
In this community years, months or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo (b) County Sullivan
(c) City or town Green Castle (If outside city or town limits, write "RURAL") 105
(d) Street No. (If rural, give location) 0
(e) Citizen of foreign country? no (Yes or No)
If yes, name country no

3. (a) PRINT FULL NAME Thomas Porter Billington
3. (b) If veteran, name war X
3. (c) Social Security No. X

4. Sex M
5. Color or race W
6. (a) Single, widowed, married, divorced M
6. (b) Name of husband or wife Elizabeth
6. (c) Age of husband or wife if alive 74 years
7. Birth date of deceased 10 (Month) 29 (Day) 1854 (Year)

8. AGE: Years 90 Months 4 Days 15 If less than one day hr. min.

9. Birthplace Adair Co (City, town, or county) Mo (State or foreign country)
10. Usual occupation Farmer
11. Industry or business

MOTHER FATHER
12. Name Rufus Billington
13. Birthplace Don't know (City, town, or county) (State or foreign country)
14. Maiden name Elizabeth Ledford
15. Birthplace Adair Co (City, town, or county) Mo (State or foreign country)

16. (a) Informant Thomas Billington
(b) Address Stahl, Mo
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-18-1945 (Month) (Day) (Year)
(c) Place: burial or cremation Mooleck Cem
18. (a) Signature of funeral director Glenn & Pendorf
(b) Address Green City Mo
19. (a) 4-2-1945 (Date received local registrar) (b) Laura Shaw-Deputy (Registrar's signature)

1551

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 3 day 14
year 1945 hour 9 minute P.M.
21. I hereby certify that I attended the deceased from 3-12- 1945 to 3-14 1945
that I last saw him alive on 3-13 1945
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Cerebral Hemmicolage	2 days
Due to Hypertension	
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)
(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 H. C. Oehmke (M.D. or other)
Address Green City Mo Date signed 3-17-45

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 10
District File Number 4-45-559
Date Filed APR 4 1945

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 Archie W. Wade

Licensed Embalmer No. 3037

P. O. Address Green Castle, 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.