S. No. 2
M—8-43
5-17-39
P I X37823

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED AUG 10 1945

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

24289

State File No.

Registration District No. 164 Primary Registration District No. 5597 Registrar's No. 67

1. PLACE OF DEATH:

(a) County Johnson

(b) City or town Centerview Rural (Centerview Rural)
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: none
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution (Specify whether
In this community 30yrs
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO. (b) County Johnson 51

(c) City or town Rural
(If outside city or town limits, write "RURAL")

(d) Street No. Centerview, MO. R. F. D.
(If rural, give location)

(e) Citizen of foreign country? no (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME Annie Belle Billingsley

3. (b) If veteran, name war no

3. (c) Social Security No. no

4. Sex Female

5. Color or race White

6. (a) Single, widowed, married, divorced married

6. (b) Name of husband or wife A. R. Billingsley

6. (c) Age of husband or wife if alive 69 years

7. Birth date of deceased Feb. (Month) 5 (Day) 1882 (Year)

8. AGE: Years 63 Months 5 Days 24 If less than one day hr. min.

9. Birthplace Plesant Hill (City, town, or county) Missouri (State or foreign country)

10. Usual occupation House keeper

11. Industry or business

FATHER
12. Name Joseph Mapes.
13. Birthplace unknown (City, town, or county) ILL. (State or foreign country)

MOTHER
14. Maiden name Rebecca Jane Jordon.
15. Birthplace unknown. (City, town, or county) IND. (State or foreign country)

16. (a) Informant A. R. Billingsley.
(b) Address Centerview. Mo.

17. (a) burial (Burial, cremation, or removal) (b) Date thereof 7-30-1945 (Month) (Day) (Year)
(c) Place: burial or cremation Sunset Hill Cem.

18. (a) Signature of funeral director Sweeney Phillips.
(b) Address Warrensburg. Mo.

19. (a) July 30 1945 (Date received local registrar) (b) Leola M. Williams (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 29 year 1945 hour 3 minute 30, A. M.

21. I hereby certify that I attended the deceased from Aug. 2, 1943, to July 29, 1945 that I last saw her alive on Alive July 27, 1945; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Cerebral Hemorrhage	4 Days
Due to Hypertensive heart disease	1 year
Due to arteriosclerosis	5 years
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 O. H. Damron Md (M. D. or other)
Address Warrensburg Mo Date signed 7-30-45

1001

(Licensed Embalmer's Statement on Reverse Side)

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 R. Q. Phillips, Registered Apprentice No. 2320, working under my personal supervision.

Signed R. Q. Phillips.

Licensed Embalmer No. 2320

P. O. Address Warrensburg, M

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.