

No. 2
12-45
17-39
X47070

FILED SEP 18 1947

Registration District No. **376**

Primary Registration District No. **6075**

Registrar's No. **308**

1. PLACE OF DEATH:

(a) County **St. Francois**
(b) City or town **Farmington RURAL St. Francois**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Missouri State Hospital No. 4
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **2 days**
(Specify whether years, months or days)

3. (a) PRINT FULL NAME **EDNA BILLINGTON**

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

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

6. (b) Name of husband or wife **Samuel E. Billington** 6. (c) Age of husband or wife if alive **Age Unknown**

7. Birth date of deceased **December 20 1891**
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
55 8 0 hr. min.

9. Birthplace **Princeton Kentucky**
(City, town, or county) (State or foreign country)

10. Usual occupation **Housewife**

11. Industry or business

12. Name **Riley Sheridan**

13. Birthplace **Unknown Unknown 9**
(City, town, or county) (State or foreign country)

14. Maiden name **Laura Bilyard**

15. Birthplace **Unknown Unknown 9**
(City, town, or county) (State or foreign country)

16. (a) Informant **Records State Hospital No. 4**

(b) Address **Farmington, Missouri**

17. (a) **Burial** (b) Date thereof **8-22-47**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Memorial Park Cem., Sikeston**

18. (a) Signature of funeral director **Albritton Funeral Home**
(b) Address **Sikeston, Missouri**

19. (a) **9-19-47** (b) **Ether Rudloff**
(Date received local registrar) (Registrar's signature)

201 (Licensed Embalmer's Statement on Reverse Side)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Scott 99**
(c) City or town **Sikeston RURAL**
(If outside city or town limits, write "RURAL")
(d) Street No. **Route 2, Box 7**
(If rural, give location)
(e) Citizen of foreign country? **No** (Yes or No)
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **August** day **20**
year **1947** hour **3** minute **00 A.** M.

21. I hereby certify that I attended the deceased from **August 18, 1947** to **August 20, 1947**
that I last saw her alive on **August 20, 1947**
and that death occurred on the date and hour stated above.

Immediate cause of death **Manical Exhaustion** Duration

Due to
Due to

Other conditions **Psychosis, type undetermined.**
(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy **No autopsy. 945**

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

23. Signature **John B. Bernhardt** (Physician or other)
Address **State Bldg. #4, Farmington** Date signed **8/22/47**

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

MOTHER FATHER

RECEIVED

District Health Officer No. 4
District File Number 947-1186
Date Filed 9-16-47

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 Carl J. Miller

Licensed Embalmer No. 3753

P. O. Address Farmington,

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.