

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

19153

State File No.

BIRTH NO.		REG. DIST. NO. 336		PRIMARY REG. DIST. NO. 6131		Registrar's No. 121	
1. PLACE OF DEATH a. COUNTY Shannon				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Mo. b. COUNTY Shannon			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Summersville Spring Creek				c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Summersville Spring Creek			
d. FULL NAME OF HOSPITAL OR INSTITUTION Township				d. STREET ADDRESS (If rural, give location) Township			
3. NAME OF DECEASED (Type or Print) Maggie		a. (First)		b. (Middle) Erma		c. (Last) Bilbrey	
4. DATE OF DEATH		(Month) (Day) (Year)		5. SEX M O		6. COLOR OR RACE W	
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Never married		8. DATE OF BIRTH Oct 24-1882		9. AGE (In years last birthday) 68		10. UNDER 1 YEAR Months 5 Days 22	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housekeeper		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Tennessee		12. CITIZEN OF WHAT COUNTRY? USA	
13a. FATHER'S NAME Louis Bilbrey		13b. MOTHER'S MAIDEN NAME Verna Wilson		14. NAME OF HUSBAND OR WIFE none		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no	
16. SOCIAL SECURITY NO.		17. INFORMANT'S SIGNATURE OR NAME Joe Bilbrey Summersville, Mo.		18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary Thrombosis ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Coronary Insufficiency DUE TO (c) Arterial Hypertension II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)		21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)	
21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?		22. I hereby certify that I attended the deceased from 1945 to April 1951, that I last saw the deceased alive on April 16, 1951, and that death occurred at 7 P. M., from the causes and on the date stated above.		23a. SIGNATURE (Degree or title) Dr. Lawrence H. Langh	
23b. ADDRESS 20 Summersville		23c. DATE SIGNED April 17, 1951		24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 4-18-51	
24c. NAME OF CEMETERY OR CREMATORY summersville		24d. LOCATION (City, town, or county) Summersville, Mo.		25. FUNERAL DIRECTOR'S SIGNATURE 447 Duncan Funeral Home Mtn View, Mo		25. ADDRESS	

(Licensed Embalmer's Statement on Reverse Side)

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

RECEIVED

MAY 17 1951

DISTRICT HEALTH OFFICE No. 6

File No.

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 _____

Student Embalmer No.

working under my personal supervision.

Student
Student Embalmer

Signed.....

John J. Luncan
Licensed Embalmer No. *2516*

P. O. Address *St. Louis 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.