

FEDERAL DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS. JAN - 4 1960

'59 0 4 5 2 4 0
STATE FILE NUMBER

Registration District No. _____

Primary Registration District No. _____

Registrar's No. _____

211864

ENDED

1. PLACE OF DEATH a. COUNTY _____ b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Louis D.A.A.</u> c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Storper G. Phillips Hosp.</u> d. DEATH <u>Dead on Arrival.</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY _____ c. CITY OR TOWN <u>St. Louis</u> d. STREET ADDRESS (If outside, give location) <u>2714 Dickson Street</u>	
Length of stay in 1b <u>37 yrs</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <u>Charles</u> Middle <u>Billinger</u> Last _____			4. DATE OF DEATH Month <u>12</u> Day <u>19</u> Year <u>59</u>				
5. SEX <u>M.</u>	6. COLOR OR RACE <u>col</u>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>8-1-1894</u>	9. AGE (last birthday) <u>65</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Labor</u>		10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (City and state or country) <u>Phillip county Ark</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S. C.</u>	
13a. FATHER'S NAME <u>George Billinger</u>		13b. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>		14. NAME OF HUSBAND OR WIFE _____			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. _____		17. INFORMANT <u>Billinger</u> Address <u>Lucille Ford, 2714 Dickson St</u>			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>2nd + 3rd degree Burns of 65% of Body</u> <u>Suffered in fire in Home (underline)</u> DUE TO (b) <u>Dec. 19th 1959</u> DUE TO (c) <u>Accident 9/16/0 16</u>		INTERVAL BETWEEN ONSET AND DEATH _____
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) _____		
PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		

19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input checked="" type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) <u>SEE ABOVE</u>			
20c. TIME OF INJURY Hour <u>2:46</u> p.m. Month, Day, Year <u>12-19-59</u>		213			
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. CITY, TOWN, OR LOCATION <u>St. Louis</u> COUNTY _____ STATE _____	

21. I attended the deceased from 3:00 Pm to _____ and last saw her/him alive on _____
 Death occurred at _____ on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <u>Frank M. [Signature]</u>	22b. ADDRESS <u>1300 Clark</u>	22c. DATE SIGNED <u>12/21/59</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>12-23-59</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Father Dixon Cemetery</u>		23d. LOCATION (City, town, or county) _____	

24. FUNERAL DIRECTOR ADDRESS <u>Geo. Loue, 2930 Dickson</u>		25. DATE RECD. BY LOCAL REG. <u>DEC 22 1959</u>		26. REGISTRAR'S SIGNATURE <u>Lead Smith, M.D.</u>	
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(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

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 _____

Signature of Student Embalmer

Signed

Leroy A. Bannister

Licensed Embalmer No. 4523

P. O. Address 4251 Washu

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.