

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **31603**

FILED OCT 13 1953

BIRTH NO. _____ REG. DIST. NO. **137** PRIMARY REG. DIST. NO. **3023** Registrar's No. **254**

1. PLACE OF DEATH a. COUNTY Henry		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Mo. b. COUNTY Henry	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Clinton Clinton		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Urich 0420	
d. FULL NAME OF HOSPITAL OR INSTITUTION CLINTON GENERAL HOSP		d. STREET ADDRESS (If rural, give location) /	

3. NAME OF DECEASED (Type or Print) Edson April Billings			4. DATE OF DEATH (Month) (Day) (Year) 9-27-1953		
a. (First)	b. (Middle)	c. (Last)			

5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH Sept. 10 1884	9. AGE (In years last birthday) 69	10. UNDER 1 YEAR Months	11. UNDER 1 YEAR Days	12. UNDER 1 YEAR Hours	13. UNDER 1 YEAR Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farmer		11. BIRTHPLACE (State or foreign country) Nebraska		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
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13a. FATHER'S NAME Alford Billings		13b. MOTHER'S MAIDEN NAME Kiza Cannon		14. NAME OF HUSBAND OR WIFE Jessie Billings			
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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. None		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Jessie M. Billings Urich Mo			
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))		MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH	
This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (a) Cerebral Hemorrhage				a month	
		ANTECEDENT CAUSES					
		Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.					
		DUE TO (b) Arteriosclerosis				2-3 years	
		DUE TO (c)					
		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 331X				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
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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)	
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
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22. I hereby certify that I attended the deceased from **June**, 1952, to **Sept 27, 1953**, that I last saw the deceased alive on **Sept. 27, 1953**, and that death occurred at **2 P. m.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) James V. Smith M.D.		23b. ADDRESS Clinton Missouri		23c. DATE SIGNED 9-31-53	
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24a. BURIAL, CREMATION, REMOVAL (Specify)		24b. DATE Sept 29-53		24c. NAME OF CEMETERY OR CREMATORY Urich		24d. LOCATION (City, town, or county) (State) Urich Mo.	
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DATE REC'D BY LOCAL REG. Sept 31-53		REGISTRAR'S SIGNATURE Florence Odum		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS W. J. Brown Urich Mo.	
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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 R. B. Kenney.....

Licensed Embalmer No. 3099.....

P. O. Address Clinton 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.