

**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

Do not use this space.

33576

1. PLACE OF DEATH

County Jackson
Township Kaw
City Kansas City

Registration District No. 399

Primary Registration District No. 1002

File No. 4347
Registered No. 4347
St. Ward

2. FULL NAME

Henry Carl Dillard

(a) Residence. No. 3017 Montgal St. 11 Ward.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 6 mos. 13 da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) married

5A. If MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Mrs Elsie Dillard

6. DATE OF BIRTH (MONTH, DAY AND YEAR) April 27 - 1906

7. AGE YEARS 21 MONTHS 6 DAYS 17 If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work formerly Graham Paper Co
(b) General nature of industry, business, or establishment in which employed (or employer) B. H. (B) Co
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN, STATE OR COUNTRY) Howard & Blair Kansas City Mo

10. NAME OF FATHER Virgil Ellis Dillard

11. BIRTHPLACE OF FATHER (CITY OR TOWN, STATE OR COUNTRY) Beaman Mo.

12. MAIDEN NAME OF MOTHER Mary Helen Vermilgen

13. BIRTHPLACE OF MOTHER (CITY OR TOWN, STATE OR COUNTRY) Warrensburg Mo.

14. INFORMANT Mrs Mary Helen Dillard Howard
(Address) 3017 Montgal Ave

15. FILED 11/16/27 M. M. Corone REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Nov 14 19 27

17. I HEREBY CERTIFY, That I attended deceased from Coroner 19 1927 to 1927, and that death occurred, on the date stated above, at 7 P. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Accidental Inhalation of Smoke - fire in room

178
1100V

CONTRIBUTORY (SECONDARY) Empyema

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH

8 DID AN OPERATION PRECEDE DEATH DATE OF

WAS THERE AN AUTOPSY yes

WHAT TEST CONFIRMED DIAGNOSIS Autopsy

(Signed) H. E. Moore, M. D.

11-14, 1927 (Address) Coroner

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Bedfordia Mo DATE OF BURIAL Nov 20 1927

20. UNDERTAKER Egler Funeral Home 1800 Linwood

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

It must be properly explained. Exact statement of occupation is very important.

10-10-1941

**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

ALL INFORMATION CALLED
FOR MUST BE WRITTEN ON
THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County Jackson
Township W. City
City W. City (No.) St. Ward

Registration District No. 399

Primary Registration District No. 1002

File No.

Registered No. 4347

2. FULL NAME

(a) Residence. No. St. Ward

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds.

...

...

...

How long in U.S., if of foreign birth? yrs. mos. ds.

...

...

...

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

M

4. COLOR OR RACE

W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)

M

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

7. AGE

YEARS

MONTHS

DAYS

If LESS than 1 day, ... hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN)

(STATE OR COUNTRY)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY)

14.

INFORMANT

(Address)

15.

FILED

11/16/27 M. M. Browne
Asst REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Nov 14 1927

17.

I HEREBY CERTIFY, That I attended deceased from

that I last saw h. alive on, 19...., and that death occurred, on the date stated above, at m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Accidental - Inhalation
of smoke - fire in
room.

CONTRIBUTORY (SECONDARY)

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH

DID AN OPERATION PRECEDE DEATH? DATE OF

WAS THERE AN AUTOPSY?

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed)

M. D

, 19 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL

DATE OF BURIAL

19

20. UNDERTAKER

ADDRESS

State
stant.

RE 5 SH ALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

S. 33576