

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

37643

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.

1. PLACE OF DEATH  
 County Monteary Registration District No. 571 File No. \_\_\_\_\_  
 Township Walker Primary Registration District No. 5769 Registered No. 50  
 City \_\_\_\_\_ (No. \_\_\_\_\_) St. \_\_\_\_\_ Ward \_\_\_\_\_

2. FULL NAME W. John Dillon  
 (a) Residence No. \_\_\_\_\_ St. \_\_\_\_\_ Ward \_\_\_\_\_  
 (Usual place of abode)  
 Length of residence in city or town where death occurred yrs. mos. 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) \_\_\_\_\_

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Feb 14 - 1861

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, _____ hrs. or _____ min.
<u>67</u>	<u>8</u>	<u>2</u>	<u>2</u>	

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) Buttn Co Mo  
 (STATE OR COUNTRY)

10. NAME OF FATHER Jack Dillon

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Don't know  
 (STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER Don't know

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Don't know  
 (STATE OR COUNTRY)

14. INFORMANT Mrs James Moore  
 (Address) Versalle Mo

15. FILED Nov 7, 1928 Just Koth  
 REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) Nov. 5 1928

17. I HEREBY CERTIFY, That I attended deceased from Nov 3 1928, to Nov 5 1928 that I last saw him alive on Nov 5 1928, and that death occurred, on the date stated above, at 4:30 P m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

Acute Endocarditis  
117A  
91A (duration) yrs. mos. 3 da.  
 CONTRIBUTORY Gastric Ulcers  
 (SECONDARY) unknown (duration) yrs. mos. da.

18. WHERE WAS DISEASE CONTRACTED Illness  
 IF NOT AT PLACE OF DEATH \_\_\_\_\_  
 DID AN OPERATION PRECEDE DEATH. \_\_\_\_\_ DATE OF \_\_\_\_\_  
 WAS THERE AN AUTOPSY. \_\_\_\_\_

WHAT TEST CONFIRMED DIAGNOSIS?  
 (Signed) Allen Drake M. D.  
Nov 2, 1928 (Address) Jamestown Mo  
 \*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. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Cole Camp Mo DATE OF BURIAL 11/7 1928

20. UNDERTAKER H. Williams ADDRESS California Mo



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CERTIFICATE OF DEATH**

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

**1. PLACE OF DEATH**

County Moniteau  
Township Walker  
City (No. .... St. .... Ward)

Registration District No. 571  
Primary Registration District No. 5769

File No. ....  
Registered No. 30

**2. FULL NAME**

W. John Dillon

(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) Widowed

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. FILE NO. Nov 7 1928 Jas. Rath REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) Nov 6 1928

17. I HEREBY CERTIFY That I attended deceased from ..... 19..... that I last saw h..... alive on ..... 19..... and that death occurred, on the date stated above, at .....

**THE CAUSE OF DEATH WAS AS FOLLOWS:**

CONTRIBUTORY (SECONDARY) (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH.....

DID AN OPERATION PRECEDE DEATH..... DATE OF.....

WAS THERE AN AUTOPT.....

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

20. UNDERTAKER ADDRESS

REGIS (A) L NOT RECEIVE A FEE FOR CERTI CATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

SUPPLEMENTARY

S-37643