

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

Do not use this space.

1314

**1. PLACE OF DEATH**

County Howard  
Township Clinton  
City Glasgow (In \_\_\_\_\_)

Registration District No. 379  
Primary Registration District No. 4223

File No. \_\_\_\_\_  
Registered No. \_\_\_\_\_  
St. \_\_\_\_\_ Ward \_\_\_\_\_

**2. FULL NAME**

Jacob Stephens Dillard

(a) Residence No. Glasgow St. \_\_\_\_\_ Ward \_\_\_\_\_  
(Usual place of abode)

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. (If nonresident give city or town and State)

**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 OR (or) WIFE OF Mrs Rosa Dillard

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

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
	58	3	18	

**8. OCCUPATION OF DECEASED**

(a) Trade, profession, or particular kind of work Barber  
(b) General nature of industry, business, or establishment in which employed (or employer) \_\_\_\_\_  
(c) Name of employer \_\_\_\_\_

9. BIRTHPLACE (CITY OR TOWN) Franklin Co Virginia  
(STATE OR COUNTRY)

10. NAME OF FATHER William Dillard

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Virginia  
(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER Mary Halliday

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Virginia  
(STATE OR COUNTRY)

14. INFORMANT Mrs Rosa Dillard  
(Address) Glasgow Mo

15. FILED 1-25-1929 W H Temple  
REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

3  
16. DATE OF DEATH (MONTH, DAY AND YEAR) 1-22-1929  
17.

I HEREBY CERTIFY, That I attended deceased from Nov \_\_\_\_\_, 1928, to Jan 23, 1929, that I last saw him alive on 1-22, 1929, and that death occurred, on the date stated above, at \_\_\_\_\_ a.m.

THE CAUSE OF DEATH WAS AS FOLLOWS:  
Autogenous reflex,  
Arterio Sclerosis -  
Cerebral thrombosis  
(duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) 1928 B1  
(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED  
IF NOT AT PLACE OF DEATH: \_\_\_\_\_

8 Did an operation precede death: \_\_\_\_\_ DATE OF \_\_\_\_\_  
WAS THERE AN AUTOPSY? \_\_\_\_\_

WHAT TEST CONFIRMED DIAGNOSIS?  
(Signed) W B Kitchen M. D.

1-24-1928 (Address) Glasgow, 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.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Glasgow Mo DATE OF BURIAL 1-24-1929

20. UNDERTAKER Vandiver & Audsley ADDRESS Glasgow Mo.

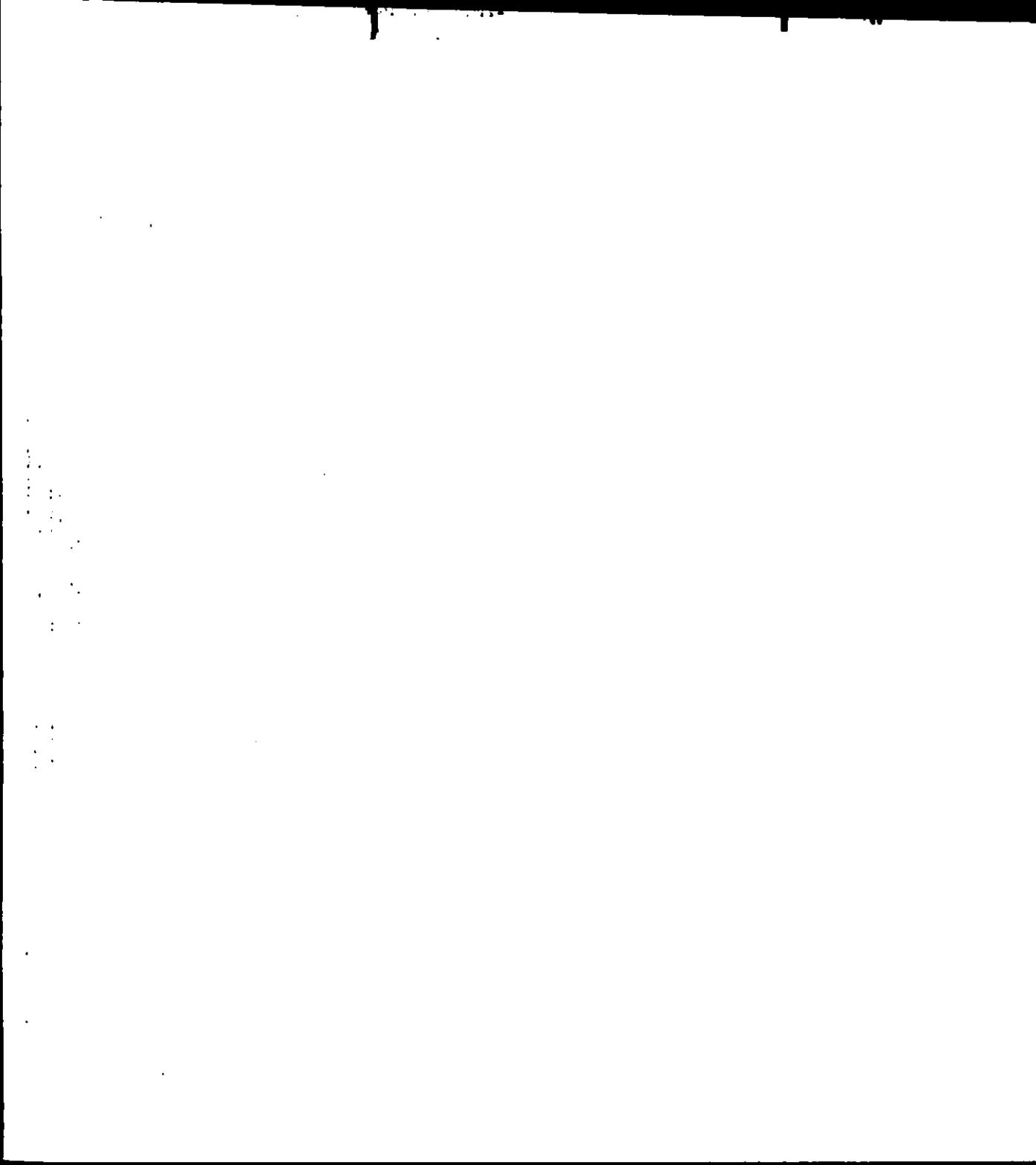
H. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

MAR 22 1929

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PARENTS

RECORD



**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 Howard

Registration District No. 279

File No. ....

Township .....

Primary Registration District No. 4-223

Registered No. ....

City Glasgow (No. ....)

St. .... Ward)

**2. FULL NAME** Jacob Stephens Dillow

(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) July 5 1870

7. AGE YEARS MONTHS DAYS  
58 | 2 | 18 | If LESS than 1 day, .... hrs. or .... min.

**8. OCCUPATION OF DECEASED**

- (a) Trade, profession, or particular kind of work ..... (duration) ..... yrs. .... mos. .... ds.
- (b) General nature of industry, business, or establishment in which employed (or employer) ..... (duration) ..... yrs. .... mos. .... ds.
- (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 1-25-1929 C.H. Temple REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

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

17. I HEREBY CERTIFY, That I attended deceased from ..... 19 ....., 19 ....., 19 ....., that I last saw h. .... alive on ....., 18 ....., 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 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 .....

WRITE CLEARLY, WITH OUTFRADING INK

PERMANENT RECORD

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.

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

SUPPLEMENTARY

5-1314