

SEP 25 1940 791 ]

Primary Registration District No. 1003

1. PLACE OF DEATH:

(a) County \_\_\_\_\_  
(b) City or town St. Louis, Mo.  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution City Sanitarium  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 5 yrs. 1 mo. 26 days  
(Specify whether  
In this community About 35 years.  
years, months or days)

3. (a) PRINT FULL NAME LUCILLE MILDRED DILLON 150

3. (b) If veteran, name war No 3. (c) Social Security No. No

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Single

6. (b) Name of husband or wife Single 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased Feb. 24, 1905  
(Month) (Day) (Year)

| 8. AGE: | Years     | Months   | Days      | If less than one day |
|---------|-----------|----------|-----------|----------------------|
|         | <u>35</u> | <u>5</u> | <u>28</u> | hr. _____ min.       |

9. Birthplace St. Louis Missouri  
(City, town, or county) (State or foreign country)

10. Usual occupation Stenographer

11. Industry or business Mo. Pac. R. R.

12. Name John Dillon

13. Birthplace St. Louis Missouri  
(City, town, or county) (State or foreign country)

14. Maiden name Lena Metzner

15. Birthplace Unknown Germany  
(City, town, or county) (State or foreign country)

16. (a) Informant H. Weggendorf  
(b) Address City Sanitarium

17. (a) Burial (b) Date thereof Aug 24 1940  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Memorial Park Cem

18. (a) Signature of funeral director [Signature]  
(b) Address 1936 St. Louis

19. AUG 24 1940 (b) [Signature]  
(Date received local registrar) (Registrar's Signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State 0 Missouri (b) County \_\_\_\_\_  
(c) City or town St. Louis 13 #  
(If outside city or town limits, write "RURAL")  
(d) Street No. ~~4118 Potomac St.~~  
3400 Arsenal St  
(If multiple location)  
(e) If foreign born, how long in U. S. A.? \_\_\_\_\_ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 21  
year 1940 hour 6:00 minute P. M.

21. I hereby certify that I attended the deceased from 7-1-38, 19\_\_\_\_, to 8-21-40, 19\_\_\_\_;  
that I last saw her alive on 8-21-40, 19\_\_\_\_;  
and that death occurred on the date and hour stated above.

Immediate cause of death Atelectasis-With Pleural Effusion-(onset 8-21-40)

Due to TBC Pleurisy (onset 8-4-40)

Due to \_\_\_\_\_  
Other conditions [Signature]  
(Include pregnancy within 3 months of death)

Major findings: \_\_\_\_\_  
Of operations \_\_\_\_\_  
Of autopsy Yes.

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:  
(a) Accident, suicide, or homicide (specify) \_\_\_\_\_  
(b) Date of occurrence \_\_\_\_\_  
(c) Where did injury occur? \_\_\_\_\_  
(City or town) (County) (State)  
(d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work? \_\_\_\_\_ (Specify type of place)  
(e) Means of injury !  
23. Signature [Signature] (M. D. or other) \_\_\_\_\_  
Address \_\_\_\_\_ Date signed \_\_\_\_\_

WRITE PLAINLY—USE 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.....

....., Registered Apprentice No.....

working under my personal supervision.

Signed.....

*Delis J. Kriffin*

Licensed Embalmer No. *3497*

P. O. Address. *1936 St. James*

**Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)**

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