

Registration District No. **791**

Primary Registration District No. **1003**

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(a) County **St. Louis, Missouri**
(b) City or town **St. Louis, Missouri**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
St. Louis City Hospital #1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **6 Days**
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **St. Louis**
(c) City or town **St. Louis** **21**
(If outside city or town limits, write "RURAL")
(d) Street No. **1437 Hogan St.**
(If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years.

3. (a) PRINT FULL NAME **Thomas Dillon**

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

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

6. (b) Name of husband or wife **none** 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased **June 17 1858**
(Month) (Day) (Year)

8. AGE: Years **about 82** Months **5** Days **24** If less than one day hr. _____ min. _____

9. Birthplace **Unknown** (City, town, or county) (State or foreign country) **9**

10. Usual occupation **Unknown** **9**

11. Industry or business _____

MOTHER FATHER { 12. Name **Unknown** **9**
13. Birthplace **Unknown** (City, town, or county) (State or foreign country)
14. Maiden name **Unknown**
15. Birthplace **Unknown** (City, town, or county) (State or foreign country)

16. (a) Informant **Father Wesley Irvine**
(b) Address **1437 Hogan St.**

17. (a) _____ (b) Date thereof **Dec. 12, 1940**
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation **Calvary Cem.**

18. (a) Signature of funeral director **Bernard J. Harris**
(b) Address **1138 - 11th St.**

19. (a) **Dec 13 1940** (b) **J. H. Bredich**
(Date of registration) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **December** day **11**, year **1940** hour **4:45** minute **A.** M.

21. I hereby certify that I attended the deceased from **December 6**, 19**40** to **December 11**, 19**40**; that I last saw him alive on **December 11**, 19**40**; and that death occurred on the date and hour stated above.

Immediate cause of death **Gen. arteriosclerosis**

Due to _____
Due to _____

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations _____
Of autopsy _____

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 **1**

23. Signature **R. Maxwell** (M. D. or other)
Address **1525 Lafayette Ave.** Date signed **12/11/40**

Not embalmed.

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 _____

Licensed Embalmer No. _____

P. O. Address _____

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, above space should be left blank.