

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

44001

State File No. \_\_\_\_\_

Registration District No. S. 11 Primary Registration District No. 1000 Registrar's No. \_\_\_\_\_

**1. PLACE OF DEATH:**

(a) County Saline

(b) City or town Liberty Twp. Rural  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: \_\_\_\_\_  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether \_\_\_\_\_)

In this community \_\_\_\_\_ years, months or days

**8. (a) PRINT FULL NAME** DELBERT JACKSON DILLON

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

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

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

7. Birth date of deceased Oct 28 1940  
(Month) (Day) (Year)

**8. AGE:**

Years	Months	Days	If less than one day
1	7		hr. min.

9. Birthplace Saline Co Mo  
(City, town, or county) (State or foreign country)

10. Usual occupation Baby

11. Industry or business \_\_\_\_\_

**MOTHER FATHER**

12. Name Albert Jackson Dillon

13. Birthplace Benton Co Mo  
(City, town, or county) (State or foreign country)

14. Maiden name Vera Marquess

15. Birthplace Benton Co Mo  
(City, town, or county) (State or foreign country)

16. (a) Informant Albert J. Dillon

(b) Address Summit Springs Mo

17. (a) Burial (b) Date thereof Dec 6 1940  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Central Union City

18. (a) Signature of funeral director R. Carter

(b) Address Summit Springs Mo

19. (a) 12/6/40 (b) [Signature]  
(Date received by local registrar) (Registrar's signature)

**2. USUAL RESIDENCE OF DECEASED:**

(a) State Mo (b) County Saline

(c) City or town Liberty Twp. Rural  
(If outside city or town limits, write "RURAL")

(d) Street No. \_\_\_\_\_ (If rural, give location)

(e) If foreign born, how long in U. S. A. \_\_\_\_\_ years.

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month Dec day 5<sup>th</sup>  
year 1940 hour 3 AM minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from Dec 4, 1940, to Dec 4, 1940; that I last saw him alive on Dec 4, 1940; and that death occurred on the date and hour stated above.

Immediate cause of death Dysphilia

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions 24  
(Include pregnancy within 3 months of death)

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

**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? Yes

(Specify type of place) \_\_\_\_\_ (e) Means of injury \_\_\_\_\_

23. Signature [Signature] (M. D. or other) \_\_\_\_\_  
Address Marshall Mo Date signed 12/6/40

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

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RECEIVED  
District Health Officer No. 8  
District File Number 1-8-40  
Date Filed

**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.