

12651  
S. No. 2  
M-1-4-41  
v. 5-17-39

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

216

State File No.

FILED FEB 24 1942

Registration District No. 791

Primary Registration District No.

Registrar's No.

945

1. PLACE OF DEATH:

(a) County \_\_\_\_\_  
(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 10 Days  
(Specify whether  
5yrs. years, months or days)  
In this community \_\_\_\_\_

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County \_\_\_\_\_  
(c) City or town St. Louis  
(If outside city or town limits, write "RURAL")  
(d) Street No. 819a Market St.  
(If rural, give location)  
(e) Citizen of foreign country? No (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month January day 7,  
year 1942 hour 3:20 minute \_\_\_\_\_ P. \_\_\_\_\_ M. \_\_\_\_\_  
21. I hereby certify that I attended the deceased from December  
29, 1941, to January 7, 1942,  
that I last saw him alive on January 7, 1942,  
and that death occurred on the date and hour stated above.

Immediate cause of death \_\_\_\_\_  
Arteriosclerosis  
Due to \_\_\_\_\_  
Due to \_\_\_\_\_

Duration

Other conditions \_\_\_\_\_  
(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? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury \_\_\_\_\_  
23. Signature J. F. Budick (M. D. or other) \_\_\_\_\_  
Address 1515 Lafayette Avenue, Date signed 1/8/42

3. (a) PRINT FULL NAME Tom Dillon

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

4. Sex Male 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 Single years

7. Birth date of deceased June 16, 1867  
(Month) (Day) (Year)

8. AGE: Years 74 Months 6 Days 22 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation Peddler

11. Industry or business Unknown

12. Name Patrick Dillon

13. Birthplace Illinois  
(City, town, or county) (State or foreign country)

14. Maiden name Jane Lury

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

16. (a) Informant Ann Morrison  
(b) Address St. Louis City Hospital #1

17. (a) Anatomical Board (b) Date thereof 1-9-42  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Washington

18. (a) Signature of funeral director W. Richter  
(b) Address 3520 Rutledge

19. (a) JAN 30 1942 (b) J. F. Budick  
(Date received local health officer) (Registrar's signature)

(Licensed Embalmer's Statement on Reverse Side)

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

006  
19  
9

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**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, fact should be so stated above.**