DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 1795

Registration District No. 89 Primary Registration District No. 3007 Registrar's No. 23

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

1. PLACE OF DEATH:

(a) County BUTLER

(b) City or town POPLAR BLUFF N.A. (If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: POPLAR BLUFF HOSPITAL (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 11 DAYS (Specify whether

In this community 3 YEARS years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County BUTLER

(c) City or town POPLAR BLUFF (If outside city or town limits, write "RURAL")

(d) Street No. 457 LESTER ST (If rural, give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME IDA MAE DILLON

3. (b) If veteran, name war —

3. (c) Social Security No. —

4. Sex FEMALE

5. Color or race WHITE

6. (a) Single, widowed, married, divorced WIDOWED

6. (b) Name of husband or wife FRANK DILLON

6. (c) Age of husband or wife if alive years

7. Birth date of deceased OCT (Month) 14 (Day) 1866 (Year)

8. AGE: Years 75 Months 3 Days 13 If less than one day hr. min.

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

10. Usual occupation HOUSEWIFE

11. Industry or business —

FATHER
12. Name CORNELIUS BACHELLOR
13. Birthplace (City, town, or county) VA (State or foreign country)

MOTHER
14. Maiden name ANN FRANKS
15. Birthplace (City, town, or county) OHIO (State or foreign country)

16. (a) Informant M R Bachellor

(b) Address 457 Lester St Poplar Bluff Mo

17. (a) REMOVAL (Burial, cremation, or removal) (b) Date thereof JAN-28-1942 (Month) (Day) (Year)

(c) Place: burial or cremation RIVERSIDE CEM. STERLING ILL

18. (a) Signature of funeral director N.T. Phelps

(b) Address Poplar Bluff Mo.

19. (a) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 27 year 1942 hour 9:30 minute P M.

21. I hereby certify that I attended the deceased from Jan. 16, 1942, to Jan 27, 1942 that I last saw her alive on Jan. 27, 1942 and that death occurred on the date and hour stated above.

Immediate cause of death Cancer of splenic flexure of colon

Due to

Due to 46

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations Cancer of colon

Of autopsy none

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) no

(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? (Specify type of place)

While at work? (e) Means of injury

23. Signature [signature] (M. D. or other)

Address Poplar Bluff Mo Date signed 2-28-42

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Office No. 2,
District File Number 242-219
Date Filed 2-11-42

FEB 5 1954

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 N. J. Phelps

Licensed Embalmer No. 3231

P. O. Address Poplar Bluff

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

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

S. No. 2B
10M—8-21-41
I X29288

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 1785

Registration District No. 89 Primary Registration District No. 3007 Registrar's No.

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

1. PLACE OF DEATH:
(a) County: Butler
(b) City or town: Poplar Bluff
(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 years, months or days)
In this community

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County
(c) City or town (If outside city or town limits, write "RURAL")
(d) Street No. (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME: Ida M. Dillon
3. (b) If veteran, name war
3. (c) Social Security No.

4. Sex: F
5. Color or race: W
6. (a) Single, widowed, married, divorced: W
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive years
7. Birth date of deceased: Oct (Month) 14 (Day) 1866 (Year)

8. AGE: Years 75 Months 3 Days If less than one day hr. min.

9. Birthplace (City, town, or county) (State or foreign country)
10. Usual occupation
11. Industry or business
MOTHER FATHER
12. Name
13. Birthplace (City, town, or county) (State or foreign country)
14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)
16. (a) Informant
(b) Address
17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation
18. (a) Signature of funeral director
(b) Address
19. (a) 1-28-42 (Date received local registrar) (b) Belle Kinne (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan. Day 27 year 1942 hour minute M.
21. I hereby certify that I attended the deceased from 19 to 19;
that I last saw h alive on 19;
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death	
Due to	
Due to	
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? (Specify type of place)
While at work? (e) Means of injury

23. Signature (M. D. or other)
Address Date signed

SUPPLEMENTARY