

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

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-43
7-39
138671

FILED APR 26 1944

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 3524

1. PLACE OF DEATH:

(a) County St. Louis

(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
BARNES HOSPITAL 0
(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

2. USUAL RESIDENCE OF DECEASED:

(a) State MO

(b) County St. Louis ⁹⁶

(c) City or town Valley Park
(If outside city or town limits, write "RURAL") ^{9P}

(d) Street No. Corman & Dutch ^{RR.}
(If rural, give location)

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

If yes, name country _____ ¹¹

3. (a) PRINT FULL NAME Mr. Herbert Dillow

3. (b) If veteran, name war World War I

3. (c) Social Security No. _____

4. Sex Male

5. Color or race White

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

6. (b) Name of husband or wife Anna Dillow

6. (c) Age of husband or wife if alive 41 years

7. Birth date of deceased Aug 7-1895
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>48</u>	<u>8</u>	<u>3</u>	_____ hr. _____ min.

9. Birthplace Orient Lowa 1.
(City, town, or county) (State or foreign country)

10. Usual occupation Assembler

11. Industry or business Waynes Elec Co

12. Name Joseph Dillow

13. Birthplace Lowa 1
(City, town, or county) (State or foreign country)

14. Maiden name Rosa Mock

15. Birthplace Lowa 1
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs Anna Dillow

(b) Address R.R. #1 Valley Park Mo

17. (a) Removal (Burial, cremation, or removal)

(b) Date thereof 4-14-44
(Month) (Day) (Year)

(c) Place: burial or cremation Highland Beer

18. (a) Signature of funeral director Heris H Bopp Inc

(b) Address Kirkwood

19. (a) APR 17 1944 (Date received local registrar)

J. F. Bussch (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 10
year 1944 hour 5 minute 18 P.M.

21. I hereby certify that I attended the deceased from March 13
1944 to April 10 1944

that I last saw him alive on April 10 1944
and that death occurred on the date and hour stated above.

Immediate cause of death Shock

Due to Exfoliative dermatitis acute

Due to Benzoin

Other conditions 15312
(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 _____

23. Signature John D. Eisner (M. D. or other)

Address BARNES HOSPITAL Date signed 4/10/44

APR 17 1944

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MAY 2

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. 4343

P. O. Address 7415 Zephyr Pl
Maplewood, N.J.

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.