

FILED MAY 7 1945
28

Registration District No. 5461

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

1. PLACE OF DEATH:

(a) County GREENE

(b) City or town Springfield, Missouri
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
Route 3 Rogersville, Missouri
(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.....

3. (a) PRINT FULL NAME Elizabeth Dillard

3. (b) If veteran, name war None

3. (c) Social Security No. None

4. Sex Female

5. Color or race White

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

6. (b) Name of husband or wife Ben Dillard

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

7. Birth date of deceased August 31, 1892
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>52</u>	<u>6</u>	<u>22</u>hr.min.

9. Birthplace Greene County, Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business In Home

12. Name Willard T. Sayers

13. Birthplace Greene County, Missouri
(City, town, or county) (State or foreign country)

14. Maiden name Mollie McClelland

15. Birthplace Webster County, Missouri
(City, town, or county) (State or foreign country)

16. (a) Informant Miss Mary Margaret Dillard

(b) Address Springfield, Missouri

17. (a) Burial (b) Date thereof 2/28/45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation East Lawn Cemetery

18. (a) Signature of funeral director Alma Lohmeyer Funeral Home

(b) Address Springfield, Missouri

19. (a) March 2-45 (b) Mo. Frank Smith
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Greene

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

(d) Street No. Route 3
(If rural, give location)

(e) Citizen of foreign country? i (Yes or No)
If yes, name country.....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month February day 23,
year 1945 hour 3 minute P. M.

21. I hereby certify that I attended the deceased from his Physician in attendance 19.....
that I last saw him alive on..... 19.....
and that death occurred on the date and hour stated above.

Immediate cause of death Suicide by firearm

Due to Bullet wound of head

Due to.....

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

Major findings:
Of operations 164c

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) Suicide

(b) Date of occurrence Feb. 23, 1945

(c) Where did injury occur? Greene Mo
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?
In from home
(Specify type of place)

While at work? no (e) Means of injury 23 rifle

23. Signature Monroe C Stone Coroner (M. D. or other)
Address Springfield, Mo Date signed 2-26-45

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.....

E. A. Roof

Licensed Embalmer No.....

3044

P. O. Address.....

Springfield, Mo

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.