DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED DEC 12 1945

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 38682

Registration District No. 324 | Primary Registration District No. 302 | Registrar's No. 165

1. PLACE OF DEATH:

(a) County: Saline

(b) City or town: Marshall, Mo. (If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Fitzgibbons Hospital (If not in hospital or institution, write street number or location) 0

(d) Length of stay: In hospital or institution ____ (Specify whether years, months or days) In this community: All His Life

2. USUAL RESIDENCE OF DECEASED:

(a) State: Missouri (b) County: Saline 97

(c) City or town: Marshall (If outside city or town limits, write "RURAL") 1

(d) Street No.: 1108 Olsen St. (If rural, give location) 2

(e) Citizen of foreign country? No. (Yes or No) 0

If yes, name country ____

3. (a) PRINT FULL NAME: William Morton Dille

3. (b) If veteran, name war: #

3. (c) Social Security No.: #

4. Sex: Male 0

5. Color or race: White

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

6. (b) Name of husband or wife: Rachel L. Level

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

7. Birth date of deceased: March 30 (Month) 1869 (Year) (Day)

8. AGE: Years	Months	Days	If less than one day
76	7	4	____ hr. ____ min.

9. Birthplace: Gilliam (City, town, or county) Mo. (State or foreign country) 0

10. Usual occupation: Farmer

11. Industry or business: " "

MOTHER FATHER

12. Name: Willis N. Dille 0

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

14. Maiden name: Caroline Keyton

15. Birthplace: Unknown (City, town, or county) (State or foreign country) 4

16. (a) Informant: Mitchell Dille

(b) Address: Marshall, Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: 11/6/45 (Month) (Day) (Year)

(c) Place: burial or cremation: Gilliam Cemetery

18. (a) Signature of funeral director: J. Leslie Burrus

(b) Address: Marshall, Mo.

19. (a) 11-6-1945 (Date received local registrar) (b) Mrs T. O. Westbrook (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov. day 4 year 1945 hour 9:11 minute A.M.

21. I hereby certify that I attended the deceased from Mar. 28, 1945 to Nov. 4, 1945 that I last saw him alive on Nov. 4, 1945 and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Diabetes Mellitus	Years
Due to: Fracture R. Femur	9 mo.
Due to: Hypertension	?

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations

Of autopsy

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

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) 77

(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: C. A. McDurney M.D. (M.D. or other)

Address: Slater Date signed 11/5/45

1215 - (Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 8
District File Number
Date Filed 12-11-45

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 Reily Taylor

Licensed Embalmer No. 3237

P. O. Address Marshall M

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.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. Dec

Registration District No. 324 Primary Registration District No. 3072 Registrar's No. 165

1. PLACE OF DEATH:

(a) County Saline

(b) City or town Marshall
(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)

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 William M. Dille

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex M

5. Color or race W

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

6. (b) Name of husband or wife

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

7. Birth date of deceased Mar (Month) 30 (Day) 1867 (Year)

8. AGE: Years 76 Months 2 Days 1 If less than one day hr. min.

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

10. Usual occupation

11. Industry or business

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

MOTHER
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) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. **DATE OF DEATH:** Month Day
year 1945 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 Fell at home	May 2, 1945
Due to Low grade osteomyelitis	
Due to developed that did not respond to the sulfas or penicillin	
Other conditions (Include pregnancy within 3 months of death) Fracture fixed by pin	
Major findings: Of operations	
Of autopsy 1860-58	

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) Accident - fall

(b) Date of occurrence May 2, 1945

(c) Where did injury occur? Home (City or town) Saline (State) Mo

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

While at work? No (e) Means of injury Fell

23. Signature O. A. McBurney MD (M.D. or other)

Address Slater, Mo Date signed 12-20-45

SUPPLEMENTARY

SUPPLEMENTARY INFORMATION REQUESTED

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

38082