

1. PLACE OF DEATH:

(a) County Dallas
 (b) City or town Zealand Rural
 (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 3 1/2 yrs years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Dallas
 (c) City or town Zealand Rural
 (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 JOHN ALLEN DILL

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

4. Male 5. Color or hr 6. (a) Single, widowed, married, divorced, married

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive 71 years

7. Birth date of deceased Feb 29 1871
 (Month) (Day) (Year)

8. AGE: Years 75 Months 7 Days 19 If less than one day hr. _____ min. _____

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

10. Usual occupation farmer

11. Industry or business _____

12. Name Lafayette Dill

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

14. Maiden name Phoebe Stewart

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

16. (a) Informant Mary Dill

(b) Address Zealand Mo

17. (a) Burial (b) Date thereof 6-23-46
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place of burial or cremation Wt Olive

18. (a) Signature of funeral director B. Jones

(b) Address Buzzard Mo

19. (a) 11-10-46 (b) J. P. Jones
 (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 20 year 1946 hour _____ minute 4:50 P.M.

21. I hereby certify that I attended the deceased from was called Oct 20 1946 to 19 that I last saw him never saw him alive and that death occurred on the date and hour stated above.

Immediate cause of death Coronary Thromboses Duration 1 hr

Due to History typical of above mentioned disease

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

Major findings: Of operations none Of autopsy none

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 G. J. Hummer (M. D. or other) MD

Address Buffalo Date signed 10-25-46

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

MOTHER FATHER

Date Filed 11/14/46
L. H. HARRIS, Registrar
Office No. 7
RECEIVED

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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..... *M. A. Jones*

Licensed Embalmer No. *4329*

P. O. Address *Buffalo, 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.