

No. 2
-5-43
-17-39
X36671

FILED APR 9 1947

Registration District No. 308

Primary Registration District No. 6247

Registrar's No. 7

1. PLACE OF DEATH:

(a) County Washington
(b) City or town Rural-Johnson Township
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Sullivan, Mo. Rt. #5
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community 30 Years
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Washington
(c) City or town Rural - Johnson Township
(If outside city or town limits, write "RURAL")
(d) Street No. Sullivan, Mo. Rt. # 5
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Mary Josephine Dilks

3. (b) If veteran, name war No. 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 Samuel Stephen Dilks
6. (c) Age of husband or wife if alive XX years
7. Birth date of deceased June 12 1865
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
81 9 16 hr. min.

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

10. Usual occupation At Home

11. Industry or business XXXX

MOTHER FATHER
12. Name Unknown Hults
13. Birthplace Unknown Unknown
(City, town, or county) (State or foreign country)
14. Maiden name Unknown Unknown
15. Birthplace Unknown Unknown
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Carrie Northcut

(b) Address Sullivan, Mo.

17. (a) Burial (b) Date thereof Mar. 30/47
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation I. O. O. F. Sullivan, Mo.

18. (a) Signature of funeral director [Signature]
(b) Address Sullivan, Mo.

19. (a) 3/31-47 (b) [Signature]
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 28
year 1947 hour 10:45 minute _____ A. M.

21. I hereby certify that I attended the deceased from 2-27- 1947 to 3-28- 1947
that I last saw her alive on 3-27- 1947
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral hemorrhage Duration 18 hours

Due to _____
Due to Hy. pertension stress

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

Major findings: None 93A
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)
(2) Means of injury _____

23. Signature [Signature] (M. D. or other)
Address Sullivan, Mo. Date signed 3/31/47

339 (Licensed Embalmer's Statement on Reverse Side)

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

RECEIVED

District Health Officer No. 4

District File Number 447-497

Date Filed 4-8-47

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 Robert M. Murray

Licensed Embalmer No. 37490

P. O. Address Sullivan, 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.