

STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 12286

FILED APR 8 1947

Registration District No. 8

Primary Registration District No. 4547

Registrar's No. 23

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

1. PLACE OF DEATH:

(a) County Worth

(b) City or town Grant City  
(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 49 years (Specify whether years, months or days)

3. (a) PRINT FULL NAME Breta Ethel Dillon

3. (b) If veteran, name war: \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex female 5. Color or race white 6. (a) Single, widowed, married, divorced single

6. (b) Name of husband or wife: \_\_\_\_\_ 6. (c) Age of husband or wife if alive: \_\_\_\_\_ years

7. Birth date of deceased Dec 15 1894  
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>73</u>	<u>1</u>	<u>7</u>	hr. min.

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

10. Usual occupation house keeper

11. Industry or business \_\_\_\_\_

12. Name Isaac Dillon

13. Birthplace Morroe Co. Ohio  
(City, town, or county) (State or foreign country)

14. Maiden name Jane Rapp

15. Birthplace Lawrence Co. Ohio  
(City, town, or county) (State or foreign country)

16. (a) Informant Sherman Dillon  
(b) Address Denver, Mo

17. (a) burial (b) Date thereof 3-25-47  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation: Grant City Cemetery

18. (a) Signature of funeral director Arch. C. Duffee  
(b) Address Grant City, Mo

19. (a) Mar. 27, 1947 (b) Leta E. Newen  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Worth

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

(d) Street No. \_\_\_\_\_ (If rural, give location)

(e) Citizen of foreign country? no (Yes or No)  
If yes, name country: \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 22  
year 1947 hour 11 minute 45 A. M.

21. I hereby certify that I attended the deceased from January, 1947, to March 22, 1947;  
that I last saw him alive on 22 March, 1947;  
and that death occurred on the date and hour stated above.

Immediate cause of death: Coronary Occlusion

Due to Arterio-sclerotic heart disease

Due to 7 Coronary Arteries

Other conditions (Include pregnancy within 3 months of death)

Major findings:  
Of operations: 930  
Of autopsy: \_\_\_\_\_

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 Frank B. Motterson M.D. (M. D. or other) \_\_\_\_\_  
Address Grant City, Mo Date signed 3/24/47

Duration 50 minutes

PHYSICIAN \_\_\_\_\_  
Underline the cause to which death should be charged statistically.

**DISTRICT HEALTH OFFICE  
Cameron, Mo.**

---

---

**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..... *Arch. C. Traylor* .....

Licensed Embalmer No. *3752* .....

P. O. Address..... *Grant City, 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.**