

No. 2  
-12-45  
5-17-39  
I X47070

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **32039**  
Registrar's No. **301**

FILED OCT 3 1947

Registration District No. **274**

Primary Registration District No. **3052**

1. PLACE OF DEATH:  
(a) County **Pettis**  
(b) City or town **Sedalia**  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
**408 South Engineer**  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_  
(Specify whether  
In this community **25 years in Sedalia**  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:  
(a) State **Missouri** (b) County **Pettis**  
(c) City or town **Sedalia**  
(If outside city or town limits, write "RURAL")  
(d) Street No. **408 South Engineer**  
(If rural, give location)  
(e) Citizen of foreign country? **no** (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME **Austin David Dillon**  
3. (b) If veteran, name war **none**  
3. (c) Social Security No. **none**

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month **Sept.** day **8**  
year **1947** hour **11:00** minute **P.** M.

4. Sex **Male**  
5. Color or race **White**  
6. (a) Single, widowed, married, divorced **Widowed**  
6. (b) Name of husband or wife **Laura Belle Stone**  
6. (c) Age of husband or wife if alive **deceased** years  
7. Birth date of deceased **December 5, 1875**  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19**47**, to **9-8**, 19**47**,  
that I last saw him alive on **9-8**, 19**47**,  
and that death occurred on the date and hour stated above.  
Immediate cause of death **Coronary Occlusion** Duration **?**

8. AGE: Years **71** Months **9** Days **4**  
If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

Due to **Hypertension Arterio-Sclerotic Myo. Carditis**  
Due to \_\_\_\_\_

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

Other conditions (Include pregnancy within 3 months of death)

10. Usual occupation **Laborer**

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

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

Major findings: Of operations \_\_\_\_\_

12. Name **unknown**

Of autopsy \_\_\_\_\_

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

14. Maiden name **unknown**

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

16. (a) Informant **Albert Dillon (son)**

(b) Address **1300 East Third, Sedalia, Mo.**

17. (a) **Rural** (b) Date thereof **9/11/47**  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Vossailles Mo.**

18. (a) Signature of funeral director **Maune Ewing**  
(b) Address **Sedalia, Mo.**

19. (a) **9/10/47** (b) **Betty Yeager**  
(Date received local registrar) (Registrar's signature)

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)

23. Signature **Therese B. Young** (D. or other) **Th**  
Address **Sedalia, Mo.** Date signed **9-9-47**

(Licensed Embalmer's Statement on Reverse Side)

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

MOTHER FATHER

RECEIVED

District Health Officer No. 8,

District File Number \_\_\_\_\_

Date Filed \_\_\_\_\_

10-2-77

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 \_\_\_\_\_

*Ruane Ewing*

Licensed Embalmer No. \_\_\_\_\_

3847

P. O. Address \_\_\_\_\_

*Sedalia 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.