

S. No. 2
M-5-43
5-17-39
I X36671

FILED MAY 10 1948

Registration District No. **290**

Primary Registration District No. **5771**

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

1. PLACE OF DEATH:

(a) County **Mercer**

(b) City or town **South Lineville, Mo.**
(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 **57 years** (years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo.** (b) County **Mercer**

(c) City or town **South Lineville, Mo.**
(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 _____

3. (a) PRINT FULL NAME **Martha Isabelle Dillon**

3. (b) If veteran, name war _____ 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 **Willis Dillon** 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased **Nov. 19, 1872**
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	75	4	29	hr. min.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **April** day **18** year **1948** hour **10** minute **30 A. M.**

21. I hereby certify that I attended the deceased from **April 10** to **April 18**, 19**48**, that I last saw him alive on **April 10**, 19**48**, and that death occurred on the date and hour stated above.

Immediate cause of death **Influenza**

Due to _____	Duration _____
Due to _____	Duration _____
Other conditions (include pregnancy within 3 months of death) _____	Duration _____
Major findings: Of operations 33B	Duration _____
Of autopsy _____	Duration _____

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

9. Birthplace **Blandensville Ill.**
(City, town, or county) (State or foreign country)

10. Usual occupation **Housekeeper**

11. Industry or business **Own Home**

MOTHER FATHER { 12. Name **Nathan Mustain**

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

14. Maiden name **Albada Foster**

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

16. (a) Informant **Mrs. Ethel M. Lense**

(b) Address **Lineville, Iowa**

17. (a) **Burial** (b) Date thereof **April 21, 1948**
(Burial, cremation, or removal to cemetery) (Month) (Day) (Year)

(c) Place: burial or cremation **Evergreen Cemetery, Lineville, Iowa**

18. (a) Signature of funeral director **J. J. Trumble**

(b) Address **Lineville, Iowa**

19. (a) **4-30-48** (b) **M. J. Ruth**
(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) _____ (Means of injury)

23. Signature **C. E. South** (M. D. or other)

Address **Lineville, Ia** Date signed **Apr 26 48**

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

Paul L. Greuler

Licensed Embalmer No.

3967

P. O. Address

Linville Grove

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.