

FILED JAN 11 1949

State File No. _____

Registration District No. 207

Primary Registration District No. 5757

Registrar's No. 1

1. PLACE OF DEATH:

(a) County marion
(b) City or town Rural Johnson
(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 50 years years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County Marion
(c) City or town Rural (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

Evertt Dillon

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

4. Sex MD 5. Color or race W 6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Gosie 6. (c) Age of husband or wife if alive 60 years
7. Birth date of deceased 2 - 5 - 1884
(Month) (Day) (Year)

8. AGE: Years 64 Months 9 Days 27 If less than one day hr. _____ min. _____

9. Birthplace marion co MO
(City, town, or county) (State or foreign country)

10. Usual occupation Farmer

11. Industry or business _____

12. Name Wm Dillon

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

14. Maiden name Sallie Hawkins

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

16. (a) Informant Flory Dillon

(b) Address St James MO

17. (a) Burial (b) Date thereof 12-5-48
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Dillon Cem

18. (a) Signature of funeral director Orville Lecklich

(b) Address St James MO

19. (a) 1-3-49 (b) Pauline Howard
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 12 day 2
year 48 hour 5:00 minute A M.

21. I hereby certify that I attended the deceased from 11-2-48
_____, 19____, to 12-2, 1948;

that I last saw him alive on 12-1-48, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death Cardiac failure

Due to Hypertension Duration 3wks

Due to Atherosclerosis ?

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy 97

Duration
3wks
3yrs
?
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) (of Means of injury)

3. Signature Dr. Tucker (M. D. or other) _____

Address St James Date signed 12-6-48

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

MOTHER FATHER

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.....

..... *me*, Registered Apprentice No.....
working under my personal supervision.

Signed..... *Paul E. Lieklich*

Licensed Embalmer No..... *3546*

P. O. Address..... *St James m*

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.