

FILED APR 15 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 2972

No. 300
10-48

#95759

BIRTH NO. REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 2972

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| 1. PLACE OF DEATH a. COUNTY | | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Mo. b. COUNTY | |
| b. CITY (If outside corporate limits, write RURAL and give township) St. Louis, Mo. | | c. CITY (If outside corporate limits, write RURAL and give township) St. Louis | |
| c. LENGTH OF STAY (In this place) | | d. STREET ADDRESS (If rural, give location) 2719 Sullivan Ave. | |
| d. FULL NAME OF HOSPITAL OR INSTITUTION St. Louis City Hospital #1 | | | |

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|-------------------------------------|---------------------|-------------|-------------------|---|
| 3. NAME OF DECEASED (Type or Print) | a. (First) MARGARET | b. (Middle) | c. (Last) DILLMAN | 4. DATE OF DEATH (Month) (Day) (Year) March 30, 1949 |
|-------------------------------------|---------------------|-------------|-------------------|---|

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|--------------|------------------------|--|--------------------------|------------------------------------|-------------------------|-----------------------|------------------------|-----------------------|
| 5. SEX F. | 6. COLOR OR RACE W. | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) W. | 8. DATE OF BIRTH 1862 | 9. AGE (In years last birthday) 87 | 10. UNDER 1 YEAR Months | 11. UNDER 1 YEAR Days | 12. UNDER 1 YEAR Hours | 13. UNDER 1 YEAR Min. |
|--------------|------------------------|--|--------------------------|------------------------------------|-------------------------|-----------------------|------------------------|-----------------------|

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| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) at home | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) St. Louis, Mo. | 12. CITIZENSHIP OF WHAT COUNTRY? |
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| 13a. FATHER'S NAME Patrick Terrell | 13b. MOTHER'S MAIDEN NAME Mary Murphy | 14. NAME OF HUSBAND OR WIFE John Dillman |
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| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no | 16. SOCIAL SECURITY NO. | 17. INFORMANT'S SIGNATURE OR NAME ADDRESS Mr. James J. Kickham, 2719 Sullivan |
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| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death. | I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Infarction of myocardium</u> | | INTERVAL BETWEEN ONSET AND DEATH <u>7 hours</u> |
| | ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Arteriosclerotic coronary thrombosis</u> | | |
| | DUE TO (c) <u>Coronary arteriosclerosis</u> | | |
| II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Senile Psychosis</u> | | <u>9/16</u> | 20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> |

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| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> |
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| 21a. ACCIDENT SUICIDE HOMICIDE (Specify) | 21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) |
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| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 21f. HOW DID INJURY OCCUR? |
|---|--|----------------------------|

22. I hereby certify that I attended the deceased from 3/18/49 to 3/30/49, 1949, that I last saw the deceased alive on 3/30/49, 1949, and that death occurred at 6:40 pm, from the causes and on the date stated above.

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| 23a. SIGNATURE (Degree or title) <u>Donald P. Taylor M.D.</u> | 23b. ADDRESS 1515 Lafayette Ave., | 23c. DATE SIGNED 3/30/49 |
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|---|---------------------------|--|---|
| 24a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 24b. DATE Apr. 4, 1949 | 24c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery | 24d. LOCATION (City, town, or county) (State) St. Louis, Mo. |
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| DATE REC'D BY LOCAL REG. APR 1 1949 | REGISTRAR'S SIGNATURE <u>J. B. Fasater</u> | 25. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur H. Kowalski</u> | ADDRESS 940 Lindell Blvd. |
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(Licensed Embalmer's Statement (on Reverse Side))

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

210

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 _____

Student Embalmer No. _____

working under my personal supervision.

Signed _____

W. VanMatre

Signed _____
Student Embalmer

Licensed Embalmer No. *2825*

P. O. Address *4340 Lafayette*

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.