

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

DR. WHITE

31486

State File No. ....

59566  
FILED OCT 13 1953

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 128 PRIMARY REG. DIST. NO. 2000 Registrar's No. 926-D

1. PLACE OF DEATH a. COUNTY <u>GREENE</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>MISSOURI</u> b. COUNTY <u>GREENE</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>SPRINGFIELD</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>SPRINGFIELD</u>	
c. LENGTH OF STAY (In this place) <u>LIFE</u>		d. STREET ADDRESS (If rural, give location) <u>1257 E. MINOTA</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>BURGE HOSP.</u>			

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
<u>INFANT SON OF MR. MRS. JAMES W. DILLARD</u>				<u>OCT. 1, 1953</u>

5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED, (Specify) <u>NEVER MARRIED</u>	8. DATE OF BIRTH <u>SEPT. 29, 1953</u>	9. AGE (In years last birthday) IF UNDER 1 YEAR Months Days Hours Min. <u>2</u>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>INFANT</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Infant</u>	11. BIRTHPLACE (State or foreign country) <u>SPRINGFIELD, MISSOURI</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
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13a. FATHER'S NAME <u>JAMES W. DILLARD</u>	13b. MOTHER'S MAIDEN NAME <u>MARY LOU LONG</u>	14. NAME OF HUSBAND OR WIFE <u>X</u>
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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) <u>NO</u>	16. SOCIAL SECURITY NO. <u>NO</u>	17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>JAMES W. DILLARD SPRINGFIELD, MO.</u>
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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, asphyxia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs</u>
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Atelectasis lungs</u>		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Edema Brain</u> DUE TO (c) <u>Trauma of a normal delivery</u>		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input checked="" 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) <u>7620</u>
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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?
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22. I hereby certify that I attended the deceased from Sept 30, 1952, to 1 Oct, 1953, that I last saw the deceased alive on 1 Oct, 1952, and that death occurred at 9 a.m., from the causes and on the date stated above.

23a. SIGNATURE <u>[Signature]</u> (Degree or title) <u>M.D.</u>	23b. ADDRESS <u>609 Chery Springfield</u>	23c. DATE SIGNED <u>2 Oct 53</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	24b. DATE <u>10/2/53</u>	24c. NAME OF CEMETERY OR CREMATORY <u>WHITE CHAPEL</u>	24d. LOCATION (City, town, or county) (State) <u>SPRINGFIELD, MO.</u>
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DATE REC'D BY LOCAL REG. <u>10-5-53</u>	REGISTRAR'S SIGNATURE <u>[Signature]</u>	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>H. H. LOHMEYER SPRINGFIELD, MO.</u>
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

**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.

Student .....  
Student Embalmer

Signed *Lucius T. Swadlow*

Licensed Embalmer No. 4815

P. O. Address *Springfield*

**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.