

FILED SEP 12 1955

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH25811  
State File No. 785

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 128 PRIMARY REG. DIST. NO. 2000 Registrar's No. 785

1. PLACE OF DEATH a. COUNTY <b>Greene</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Missouri</b> b. COUNTY <b>Greene</b>			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>Springfield</b>		c. LENGTH OF STAY (In this place)		c. CITY OR TOWN <b>Springfield</b>		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>1317 W. Thoman</b>				e. STREET ADDRESS (If rural, give location) <b>1317 W. Thoman</b>			
3. NAME OF DECEASED (Type or Print) a. (First) <b>EDMUND</b>		b. (Middle) <b>WESLEY</b>		c. (Last) <b>DILLARD</b>		4. DATE OF DEATH (Month) (Day) (Year) <b>Sept. 4, 1955</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>	8. DATE OF BIRTH <b>31 Aug. 1879</b>		9. AGE (In years last birthday) <b>76</b>	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Retired</b>		11. BIRTHPLACE (City and State or Foreign Country) <b>Missouri</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13a. FATHER'S NAME <b>Allen Dillard</b>		13b. MOTHER'S MAIDEN NAME <b>Alessia Queackick</b>		14. NAME OF HUSBAND OR WIFE <b>Minnie Dillard</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>No</b>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <b>Minnie Dillard Springfield, Mo.</b>			
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, ashenia, etc. It means the disease, injury, or complication which caused death.				MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Cerebral hemorrhage</b> INTERVAL BETWEEN ONSET AND DEATH <b>hrs.</b> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <b>Hypertensive Cardio-Vascular disease</b> DUE TO (c) <b>Arteriosclerosis</b>			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <b>Arteriosclerosis</b>				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <b>Springfield, Mo. Greene County Missouri</b>		21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)	
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21f. HOW DID INJURY OCCUR?			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		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 <b>21 Jan.</b> , 19 <b>53</b> , to <b>4 Sept.</b> , 19 <b>55</b> , that I last saw the deceased alive on <b>4 Sept.</b> , 19 <b>55</b> , and that death occurred at <b>1:20 P.M.</b> , from the causes and on the date stated above.							
23a. SIGNATURE <b>Lawrence E. Smith, M.D.</b> (Degree or title)				23b. ADDRESS <b>1630 N. Jefferson Springfield, Mo.</b>		23c. DATE SIGNED <b>7 Sept 55</b>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24b. DATE <b>9-8-55</b>		24c. NAME OF CEMETERY OR CREMATORY <b>Robberson Prairie</b>		24d. LOCATION (City, town, or county) (State) <b>Greene County, Missouri</b>	
DATE REC'D BY LOCAL REG. <b>9-7-55</b>		REGISTRAR'S SIGNATURE <b>Paul Williamson</b>		FUNERAL DIRECTOR'S SIGNATURE <b>J. W. Hingner</b>		ADDRESS <b>Springfield, Mo.</b>	

(Licensed Embalmer's Statement on Reverse Side)

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.....  
Signature of Student Embalmer

Signed.....  
*Ogden Stone Jr*

Licensed Embalmer No. 417

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.