

FILED NOV 7 1955

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **32404**
Registrar's No. **286**

BIRTH NO. _____ REG. DIST. NO. **47** PRIMARY REG. DIST. NO. **3008**

1. PLACE OF DEATH a. COUNTY Callaway		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Mo b. COUNTY Osage	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Fulton		c. CITY OR TOWN Freeburg	d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION State Hospital No 7		e. STREET ADDRESS (If rural, give location) Unk	

3. NAME OF DECEASED (Type or Print) a. (First) JOSEPH	b. (Middle) -	c. (Last) DILL	4. DATE OF DEATH (Month) (Day) (Year) Oct 30 1955
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5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Single	8. DATE OF BIRTH 17 Nov 1881	9. AGE (In years last birthday) 73	IF UNDER 1 YEAR Months 11 Days 13	IF UNDER 24 HRS. Hours - Min. -
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer	10b. KIND OF BUSINESS OR INDUSTRY FARM	11. BIRTHPLACE (City and State or Foreign Country) Mo	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13a. FATHER'S NAME John Dill	13b. MOTHER'S MAIDEN NAME Sadie Thine	14. NAME OF HUSBAND OR WIFE -
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Unk (If yes, give war or dates of service)	16. SOCIAL SECURITY NO. Unk	17. INFORMANT'S SIGNATURE OR NAME State Hospital Records	ADDRESS Fulton, Mo
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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.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH 1 day
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Broncho Pneumonia		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) 491X		
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 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) m.	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 **9 May 1955**, to **30 Oct 1955**, that I last saw the deceased alive on **30 Oct 1955**, and that death occurred at **8:25 p.m.**, from the causes and on the date stated above.

23a. SIGNATURE F. J. Nichols (Clerk) M.D.	23b. ADDRESS Fulton, Mo	23c. DATE SIGNED 30 Oct 1955
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 11/2/55	24c. NAME OF CEMETERY OR CREMATORY Freeburg	24d. LOCATION (City, town, or county) (State) Freeburg, Mo
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DATE REC'D BY LOCAL REG Oct 30 1955	REGISTRAR'S SIGNATURE Martha Lawrence	426-10	25. EMERALD DIRECTOR'S SIGNATURE W. O. Cunningham	ADDRESS Osage, Mo
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WRITE PLAINLY—USING UNEADING BLACK INK—MAKE A PERMANENT RECORD

NOV 8 1955

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 *H. C. Birmingham*

Licensed Embalmer No. 366

P. O. Address *Perma*

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.