

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

3304

FILED NOV 4 1955

State File No.

BIRTH NO. _____		REG. DIST. NO. <u>146</u>		PRIMARY REG. DIST. NO. <u>3026</u>		Registrar's No. <u>414</u>		
1. PLACE OF DEATH a. COUNTY <u>Jackson</u>				2. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Jackson</u>				
b. CITY OR TOWN <u>Independence</u>		c. LENGTH OF STAY (in this place) <u>6 days</u>		c. CITY OR TOWN <u>Independence</u>		d. Is residence within limits of city or incorporated town? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Independence Sanitarium</u>				e. STREET ADDRESS (If rural, give location) <u>616 West Nickell St</u>				
3. NAME OF DECEASED (Type or Print) a. (First) <u>Alma</u> b. (Middle) <u>R.</u> c. (Last) <u>Dillee</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>Oct 25-1955</u>					
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Cauc.</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>		8. DATE OF BIRTH <u>Feb-17-1881</u>		
9. AGE (In years last birthday) <u>74</u>		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 24 HRS. Hours _____ Min. _____				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ret. Mgr. Store Room</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Restaurant</u>		11. BIRTHPLACE (City and State or Foreign Country) <u>Barton County - Kansas</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13a. FATHER'S NAME <u>George Dillee</u>			13b. MOTHER'S MAIDEN NAME <u>Mary Smith</u>		14. NAME OF HUSBAND OR WIFE <u>Piggie Adillee</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)			16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Piggie A. Dillee, Indep. Mo</u>			
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 I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Bilateral Subarachnoid Hemorrhage due to Rupture of congenital aneurysm of circle of Willis</u> DUE TO (b) _____ DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS <u>Pulmonary Infarction Rt upper lobe</u> <u>Carcinoma of Bladder Grade I</u>				INTERVAL BETWEEN ONSET AND DEATH <u>6 days</u> <u>330X</u> <u>2 days</u> <u>months</u>
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
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) _____				
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? _____				
22. I hereby certify that I attended the deceased from <u>10/19</u> , 19 <u>51</u> , to <u>10-25-55</u> , 19____, that I last saw the deceased alive on <u>10-25</u> , 19 <u>55</u> , and that death occurred at <u>9:00 P.M.</u> , from the causes and on the date stated above.								
23a. SIGNATURE <u>Vance E. Link, M.D.</u> (Degree or title) <u>Drs. Grabske & Link</u>				23b. ADDRESS <u>129 West Lexington, Indep., Mo.</u>		23c. DATE SIGNED <u>10-26-55</u>		
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>Oct. 27-1955</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Mount Grove</u>		24d. LOCATION (City, town, or county) (State) <u>Independence - Mo</u>		
DATE REC'D BY LOCAL REG. <u>10-27-55</u>		REGISTRAR'S SIGNATURE <u>[Signature]</u>		FUNERAL DIRECTOR'S SIGNATURE <u>Roland R. Speaks</u>		ADDRESS <u>Indep. Mo</u>		

(Licensed Embalmer's Statement on Reverse Side)

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

APR 6 1956

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.....
Raymond M. Hardy

Licensed Embalmer No.....
4

P. O. Address.....
Indeys

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (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.