

FILED NOV 10 1955

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **35459**

BIRTH NO. _____ REG. DIST. NO. **317** PRIMARY REG. DIST. NO. **547** Registrar's No. **2427**

1. PLACE OF DEATH a. COUNTY St. Louis Co.		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 town) Richmond Hts.	c. LENGTH OF STAY (in this place) 10 Days	c. CITY OR TOWN St. Louis	d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Marys Hospital		e. STREET ADDRESS (If rural, give location) 4601 Maryland 2111	

3. NAME OF DECEASED (Type or Print) a. (First) Paul b. (Middle) _____ c. (Last) Dillon			4. DATE OF DEATH (Month) (Day) (Year) 10-20-1955
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5. SEX mal.	6. COLOR OR RACE white	7. MARRIED NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH Sept. 19 1877	9. AGE (In years last birthday) 78	If UNDER 1 YEAR Months _____ Days _____	If UNDER 100 HRS. Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Lawyer		10b. KIND OF BUSINESS OR INDUSTRY Own Bys.		11. BIRTHPLACE (City and State or Foreign Country) St. Louis Mo.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
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13a. FATHER'S NAME Daniel Dillon		13b. MOTHER'S MAIDEN NAME Mary Jane Fox		14. NAME OF HUSBAND/OR WIFE Laura Coale Dillon	
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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. none		17. INFORMANT'S SIGNATURE OR NAME Mrs. John F. Weber ADDRESS 4618 Maryland	
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) <i>*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>		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Acute pulmonary edema				INTERVAL BETWEEN ONSET AND DEATH 2 days	
		ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) arteriosclerotic heart disease				2 yrs.	
		DUE TO (c) Prostatic hypertrophy; hemorrhagic cystitis; pyelonephritis				About 4 mos.	
		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) 4200	
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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 **1943**, 19____, to **Oct. 20, 1955**, that I last saw the deceased alive on **Oct. 20, 1955**, and that death occurred at **7:40 P.m.**, from the causes and on the date stated above.

23a. SIGNATURE G. O. Brown M.D. (Degree or title)		23b. ADDRESS G. O. Brown, M.D. 1325 South Grand Boulevard		23c. DATE SIGNED 10/21/55	
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24a. BURIAL, CREMATION REMOVAL (Specify) Removal		24b. DATE Oct 23 1955		24c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery		24d. LOCATION (City, town, or county) (State) St. Louis Mo.	
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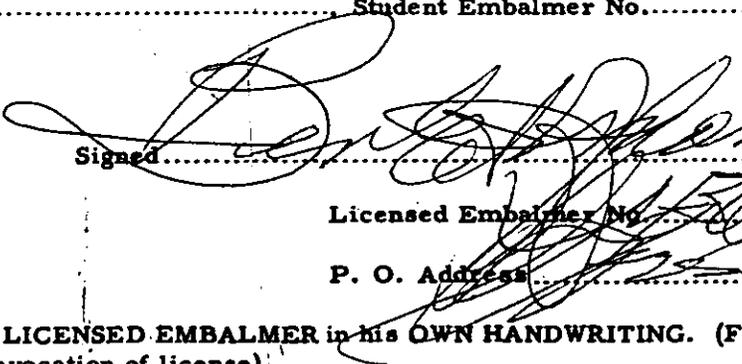
DATE REC'D BY LOCAL REG. 10-21-55		REGISTRAR'S SIGNATURE Robert K. Hambe		FUNERAL DIRECTOR'S SIGNATURE William Bro ADDRESS 3320 N. Kings highway	
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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.....
Signature of Student Embalmer

Signed.....


Licensed Embalmer No.

P. O. Address.....

**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.**