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THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED JUL 16 1956

State File No. **19621**
Registrar's No. **734**

BIRTH NO. _____ REG. DIST. NO. **42** PRIMARY REG. DIST. NO. **1000**

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

1. PLACE OF DEATH a. COUNTY Buchanan		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Buchanan	
b. CITY (If outside corporate limits, write RURAL and give town or township) St. Joseph	c. LENGTH OF STAY (in this place) 65 years	c. CITY OR TOWN St. Joseph	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 (If not hospital or institution, give street address or location) 3225 South 11th St. Parkview Sunnyslope Nursing Home		e. STREET ADDRESS (If rural, give location) 1105 S. 39th St.	
3. NAME OF DECEASED (Type or Print) a. (First) William b. (Middle) Watson c. (Last) Dillon		4. DATE OF DEATH (Month) (Day) (Year) July 1, 1956	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH June 14, 1882
9. AGE (In years last birthday) 74	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Hours	IF UNDER 1 MIN. Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. office worker		10b. KIND OF BUSINESS OR INDUSTRY Armour Meat Packing Co.	11. BIRTHPLACE (City and State or Foreign Country) Springfield, Missouri
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13a. FATHER'S NAME Felix Aubrey Dillon	
13b. MOTHER'S MAIDEN NAME Elizabeth Watson		14. NAME OF HUSBAND OR WIFE Caroline Dillon	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) yes Peace time service		16. SOCIAL SECURITY NO. 487-09-1037	
17. INFORMANT'S SIGNATURE OR NAME Caroline Dillon		ADDRESS 1105 SO. 39th St.	
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 I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) CONgestive heart failure ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) arteriosclerosis DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Parkinson's disease	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION 4500	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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)		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 8/11 , 19 43 to 7/1 , 19 56 , that I last saw the deceased alive on 6/30 , 19 56 and that death occurred at 2:30 A. m., from the causes and on the date stated above.			
23a. SIGNATURE (Degree or title) Clayton Smith, M.D.		23b. ADDRESS 218 North 7th St. Joseph, Mo.	
23c. DATE SIGNED 7-5-56			
24a. BURIAL, CREMATION, REMOVAL Burial		24b. DATE July 3, 1956	
24c. NAME OF CEMETERY OR CREMATORY Memorial Park Cemetery		24d. LOCATION (City, town, or county) (State) St. Joseph, Mo.	
DATE REC'D BY LOCAL REG. July 9, 1956		REGISTRAR'S SIGNATURE Bethel M. Allison	
25. FUNERAL DIRECTOR'S SIGNATURE Carroll Clark		ADDRESS Clark Funeral Home St. Joseph, Mo.	

(Licensed Embalmer's Statement on Reverse Side)

VS MAY 12 1959

MAR 19 1957
FEB 5 1957

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was emb

by me, or by, Student Embalmer No.....

working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed *Emm a Clark*

Licensed Embalmer No. *473*

P. O. Address *St. Joseph*

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