

MISSOURI DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH

STATE FILE NUMBER

124 - 57 - 047821

REGISTRAR'S NUMBER 235013

DELAYED FILING
Filed Oct. 25, 1993
REGISTRATION DISTRICT NO.

TYPE/PRINT
IN
PERM/
BLAC
FOR

INSTRUCTIONS
SEE OTHER SIDE
AND HANDBOOK.

DECEDENT

VS 300
Rev. 4/90
MO 580-0695
(4-90)

FOR USE BY PHYSICIAN OR INSTITUTION
Newspaper dated
NAME OF
DECEDENT

PARENTS

INFORMANT

DISPOSITION

**CAUSE OF
DEATH**

CERTIFIER

1. DECEDENT'S NAME (First, Middle, Last) Louis Dillin				2. SEX Male		3. DATE OF DEATH (Month, Day, Year) July 17, 1957		
4. SOCIAL SECURITY NO. Unk.		5a. AGE - Last Birthday (Years) 87	5b. UNDER 1 YEAR MONTHS DAYS	5c. UNDER 1 DAY HOURS MINUTES	6. DATE OF BIRTH (Month, Day, Year) Jan. 9, 1870		7. BIRTHPLACE (City and State or Foreign Country) DuBois County, Ind.	
8. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unk.				9a. PLACE OF DEATH (check only one; see instructions on other side) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (specify)				
9b. FACILITY NAME (If not institution, give street and number) Doctors' Hospital				9c. CITY, TOWN, OR LOCATION OF DEATH Poplar Bluff		9d. COUNTY OF DEATH Butler		
10. MARITAL STATUS - Married, Never Married, Widowed, Divorced (Specify) Married		11. SURVIVING SPOUSE'S NAME (If wife, give full maiden name) Elizabeth Brewer		12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired.) Merchant		12b. KIND OF BUSINESS OR INDUSTRY Grocery		
13a. RESIDENCE - STATE Missouri		13b. COUNTY Stoddard		13c. CITY, TOWN, OR LOCATION Puxico		13d. ZIP CODE 63960		
13e. STREET AND NUMBER General Delivery				13i. INSIDE CITY LIMITS <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	13g. YEARS AT PRESENT ADDRESS <input type="checkbox"/> Under 5 <input type="checkbox"/> 5-9 <input type="checkbox"/> 10-19 <input checked="" type="checkbox"/> 20 or more			
14. WAS DECEDENT OF HISPANIC ORIGIN (Specify No or Yes - If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes Specify:				15. RACE - American Indian, Black, White, etc. (Specify) White		18. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Unk.		
17. FATHER'S NAME (First, Middle, Last) Thomas Dillin				18. MOTHER'S NAME (First, Middle, Maiden Surname) Lucinda Green				
19a. INFORMANT'S NAME (Type/Print) Betty Lou Denny				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O.Box 115 Puxico, Mo. 63960				
20a. BURIAL, CREMATION, OTHER (Specify) Burial		20b. DATE OF DISPOSITION (Month, Day, Year) July 20, 1957	20c. PLACE OF DISPOSITION (Name of cemetery, crematory, or other place) Puxico Cemetery		20d. LOCATION - City or Town, State Puxico, Mo.			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE OR PERSON ACTING AS SUCH Lloyd Morgan (DEC.)			22a. NAME AND ADDRESS OF FACILITY Morgan Funeral Home, Puxico, Mo.		22b. FUNERAL ESTABLISHMENT LICENSE NUMBER NA			
23. PART I. Enter the diseases, injuries, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							Approximate Interval Between Onset and Death	
IMMEDIATE CAUSE (Final disease or condition resulting in death)		a. Unknown because hospital records destroyed						
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (disease or injury that initiated events resulting in death) LAST		b. DUE TO (OR AS A CONSEQUENCE OF):						
		c. DUE TO (OR AS A CONSEQUENCE OF):						
		d. DUE TO (OR AS A CONSEQUENCE OF):						
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								
24. IF DECEASED WAS FEMALE 10-49, WAS SHE PREGNANT IN THE LAST 90 DAYS? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk.				25a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	25b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> Yes <input type="checkbox"/> No			
26. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide 26a. (Specify)		27a. DATE OF INJURY (Month, Day, Year)	27b. TIME OF INJURY M	27c. WAS INJURY ALCOHOL-RELATED? (Not limited to decedent) <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk.	27d. INJURY AT WORK? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk.	27e. DESCRIBE HOW INJURY OCCURRED		
27f. PLACE OF INJURY - At home, farm, street, factory, office building, etc. (Specify)				27g. LOCATION (Street and Number or Rural Route Number, City or Town, State)				
28a. (Specify)		28b. To the best of my knowledge, death occurred at the time, date and place and due to the cause(s) stated. (Signature and Title) Doctor unable to sign because of age.			28c. DATE SIGNED (Month, Day, Year) Delayed Filing Unk.	28d. TIME OF DEATH		
29a. NAME AND ADDRESS OF CERTIFIER (PHYSICIAN, MEDICAL EXAMINER OR CORONER) (Type or Print) R.C. Englehart, M.D. Poplar Bluff, Mo.				29b. MO. LICENSE NUMBER Unk.	30. WAS CASE REFERRED TO MEDICAL EXAMINER/CORONER? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
31. NAME OF ATTENDING PHYSICIAN IF OTHER THAN CERTIFIER (Type or Print)		32. REGISTRAR'S SIGNATURE Richard W. Dand			33. DATE RECEIVED BY LOCAL REGISTRAR (Month, Day, Year) 10-25-93			

Filed on the basis of a statement from Betty Denny, obituary from July 17, 1957 & a picture of the tombstone

Passed away July 17, 1957

DO NOT WRITE ON THIS STUB

5a
7 - cy
7 - st
9b
9a
9c
10
12b
12a
13a
13b
13c & f
13e
13g
14
15
16
22b
23u
23 - sc1
23 - sc2
27d
27e - f
27g - st
27g - co
27g - cy
29a
29b

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 Embalmer Deceased

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.

INSTRUCTIONS FOR SELECTED ITEMS

Item 9a - Place of Death

If the death was pronounced in a hospital, check the box indicating the decedent's status at the institution (inpatient, emergency room/outpatient, or dead on arrival (DOA)). If death was pronounced elsewhere, check the box indicating whether pronouncement occurred at a nursing home, residence, or other location. If other is checked, specify where death was legally pronounced, such as a physician's office, the place where the accident occurred, or at work.

Item 13a-g - Residence of Decedent

Residence of the decedent is the place where he or she actually resided. This is not necessarily the same as "home state," or "legal residence." Never enter a temporary residence such as one used during a visit, business trip, or a vacation. Place of residence during a tour of military duty or during attendance at college is not considered as temporary and should be considered as the place of residence. If a decedent had been living in a facility where an individual usually resides for a long period of time, such as a group home, mental institution, nursing home, penitentiary, or hospital for the chronically ill, report the location of that facility in items 13a through 13g. If the decedent was an infant who never resided at home, the place of residence is that of the parent(s) or legal guardian. Do not use an acute care hospital's location as the place of residence for any infant.

Item 23 - Cause of Death

The cause of death means the disease, abnormality, injury or poisoning that caused the death, not the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. In Part I the immediate cause of death is reported on line (a). Antecedent conditions, if any, which gave rise to the cause are reported on lines (b), (c), and (d). The underlying cause should be reported on the last line used in Part I. No entry is necessary on lines (b), (c), and (d) if the immediate cause of death on line (a) describes completely the train of events. ONLY ONE CAUSE SHOULD BE ENTERED ON A LINE. Additional lines may be added if necessary. Provide the best estimate of the interval between the onset of each condition and death. Do not leave the interval blank; if unknown, so specify. In Part II, enter other important diseases or conditions that may have contributed to death but did not result in the underlying cause of death given in Part I.

**EXAMPLE OF
PHYSICIAN
CERTIFICATION:**

**CAUSE OF
DEATH**

23 PART I. Enter the diseases, injuries, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.						Approximate Interval Between Onset and Death	
IMMEDIATE CAUSE <i>(Final disease or condition resulting in death)</i> Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE <i>(disease or injury that initiated events resulting in death)</i> LAST	a.	<u>Rupture of myocardium</u> DUE TO (OR AS A CONSEQUENCE OF):				Mins.	
	b.	<u>Acute myocardial infarction</u> DUE TO (OR AS A CONSEQUENCE OF):				6 days	
	c.	<u>Chronic ischemic heart disease</u> DUE TO (OR AS A CONSEQUENCE OF):				5 years	
	d.	_____ DUE TO (OR AS A CONSEQUENCE OF):					
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>Diabetes, Chronic obstructive pulmonary disease, smoking</u>				24 IF DECEASED WAS FEMALE 10-49, WAS SHE PREGNANT IN THE LAST 90 DAYS? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk.	25a. WAS AN AUTOPSY PERFORMED? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	25b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
26. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be Determined <input type="checkbox"/> Homicide	27a. DATE OF INJURY <i>(Month, Day, Year)</i> _____	27b. TIME OF INJURY M <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk.	27c. WAS INJURY ALCOHOL-RELATED? <i>(Not limited to decedent)</i> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk.	27d. INJURY AT WORK? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk.	27e. DESCRIBE HOW INJURY OCCURRED _____		
27f. PLACE OF INJURY - At home, farm, street, factory, office building, etc. <i>(specify)</i> _____			27g. LOCATION <i>(Street and Number or Rural Route Number, City or Town, State)</i> _____				

**EXAMPLE OF
MEDICAL EXAMINER
OR CORONER
CERTIFICATION:**

**CAUSE OF
DEATH**

23 PART I. Enter the diseases, injuries, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.						Approximate Interval Between Onset and Death	
IMMEDIATE CAUSE <i>(Final disease or condition resulting in death)</i> Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE <i>(disease or injury that initiated events resulting in death)</i> LAST	a.	<u>Cerebral laceration</u> DUE TO (OR AS A CONSEQUENCE OF):				10 mins.	
	b.	<u>Open skull fracture</u> DUE TO (OR AS A CONSEQUENCE OF):				10 mins.	
	c.	<u>Automobile accident</u> DUE TO (OR AS A CONSEQUENCE OF):				10 mins.	
	d.	_____ DUE TO (OR AS A CONSEQUENCE OF):					
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				24 IF DECEASED WAS FEMALE 10-49, WAS SHE PREGNANT IN THE LAST 90 DAYS? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unk.	25a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	25b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
26. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be Determined <input type="checkbox"/> Homicide	27a. DATE OF INJURY <i>(Month, Day, Year)</i> 11/15/85	27b. TIME OF INJURY 1 p. M.	27c. WAS INJURY ALCOHOL-RELATED? <i>(Not limited to decedent)</i> <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk.	27d. INJURY AT WORK? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unk.	27e. DESCRIBE HOW INJURY OCCURRED 2-car collision-driver		
27f. PLACE OF INJURY - At home, farm, street, factory, office building, etc. <i>(specify)</i> Street			27g. LOCATION <i>(Street and Number or Rural Route Number, City or Town, State)</i> Route 4, Jefferson City, Missouri				