

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-009362
STATE FILE NUMBER

FILED MAR 26 1959

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 1270

300
-57

1. PLACE OF DEATH a. COUNTY JACKSON			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE KANSAS b. COUNTY Shawnee		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN KANSAS CITY		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN TOPEKA		81508 Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION NEUROLOGICAL HOSP.		Length of stay if in 17 1/2 yrs.	d. STREET ADDRESS (If outside, give location) 404 WEST 9th ST.		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First JOHN Middle FORREST Last DILLON II			4. DATE OF DEATH Month Mar. Day 9- Year 1959		
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 20-1880	9. AGE (In years last birthday) 78	IF UNDER 1 YEAR Months _____ Days _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY LUMBER AND OIL	11. BIRTHPLACE (City and state or country) TOPEKA, KAN.		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13a. FATHER'S NAME HIRAM PRICE DILLON		13b. MOTHER'S MAIDEN NAME SUSIE BROWN		14. NAME OF HUSBAND OR WIFE OLGA BROWN	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) YES W.W.I		16. SOCIAL SECURITY NO. None	17. INFORMANT EMMA R. WARD - TOWN HOUSE Address TOPEKA, KAN.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Heart disease.					INTERVAL BETWEEN ONSET AND DEATH 2 years
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) _____					
DUE TO (c) _____					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)		
20c. TIME OF INJURY Hour _____ Month, Day, Year _____ a.m. _____ p.m. _____					
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from 1942 to 3-9-1959 and last saw ^{her} him alive on 3-9-1959 Death occurred at 9:08 P. _____ m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) Louise Loewy M.D.		22b. ADDRESS 2625 W. Paseo.		22c. DATE SIGNED 3-9-59	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE Mch. 11, 1959	23c. NAME OF CEMETERY OR CREMATORY Topeka Cemetery		23d. LOCATION (City, town, or county) (State) Topeka Kansas
24. FUNERAL DIRECTOR D.W. NEWCOMERS SONS-KANSAS CITY		ADDRESS	25. DATE RECD. BY LOCAL REG. 3-10-59	26. REGISTRAR'S SIGNATURE Wera Marshall	

MEDICAL CERTIFICATION
Louise Loewy USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

All diseases in Part I must be causally related.

APR 15 1959

APR 14 1959

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 *Marvin D. Preston*

Licensed Embalmer No. *5040*

P. O. Address *Kansas City, Mo*

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.