

**FEDERAL BUREAU OF INVESTIGATION  
 FILED VS NOV 23 1959**

**59-041268**  
 STATE FILE NUMBER

Registration District No. 276 Primary Registration District No. 44710 Registrar's No. 35

FILED  
 DOCUMENT  
 MEDICAL CERTIFICATION  
 BY AFFIDAVIT OF

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Hhelps</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Dent</u>				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. James, Mo</u>		Length of stay in 1b <u>2 1/2 yrs</u>		c. CITY OR TOWN <u>Salem</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Federal Soldiers Home St. James, Mo</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>Washington St</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) First <u>Mary</u> Middle <u>Dillard</u> Last <u>Dillard</u>				<b>4. DATE OF DEATH</b> Month <u>11</u> Day <u>11</u> Year <u>1959</u>				
<b>5. SEX</b> <u>Female</u>	<b>6. COLOR OR RACE</b> <u>White</u>	<b>7. Married</b> <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>4-10-79</u>	<b>9. AGE</b> (last birthday) <u>80</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____		
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>housewife</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>X</u>		<b>11. BIRTHPLACE</b> (City and state or country) <u>Dent Co Missouri</u>		<b>12. CITIZEN OF WHAT COUNTRY</b> <u>U S A</u>		
<b>13a. FATHER'S NAME</b> <u>Horace Seal</u>			<b>13b. MOTHER'S MAIDEN NAME</b> <u>Joseline Unknown</u>			<b>14. NAME OF HUSBAND OR WIFE</b> <u>Benj. Dillard</u>		
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u> <input checked="" type="checkbox"/>		<b>16. SOCIAL SECURITY NO.</b> <u>X</u>		<b>17. INFORMANT</b> Address <u>Horace Dillard Salem Mo</u>				
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u>						INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>		
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)						PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	<b>20a. ACCIDENT</b> <input type="checkbox"/>	<b>SUICIDE</b> <input type="checkbox"/>	<b>HOMICIDE</b> <input type="checkbox"/>	<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in PART I or PART II of item 18.)				
<b>20c. TIME OF INJURY</b> Hour _____ a.m. _____ p.m.		Month _____ Day _____ Year _____						
<b>20d. INJURY OCCURRED WHILE AT WORK</b> <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)		<b>20f. CITY, TOWN, OR LOCATION</b>		COUNTY _____ STATE _____		
<b>21. I attended the deceased from</b> <u>2-22-58</u> to <u>11-11-59</u> and last saw her alive on <u>11-11-59</u> . Death occurred at <u>3:45</u> <u>A</u> m on the date stated above, and to the best of my knowledge, from the causes stated.								
<b>22a. SIGNATURE</b> <u>J.A. Grosskreutz MA</u> (Degree or title)				<b>22b. ADDRESS</b> <u>St. James - Mo</u>		<b>22c. DATE SIGNED</b> <u>11/14/59</u>		
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>burial</u>		<b>23b. DATE</b> <u>11-14-59</u>	<b>23c. NAME OF CEMETERY OR CREMATOR</b> <u>Mt Herman Cem</u>		<b>23d. LOCATION</b> (City, town, or county) <u>Dent Co Missouri</u>			
<b>24. FUNERAL DIRECTOR</b> <u>Spencer Funeral Home</u> ADDRESS <u>Salem, Mo</u>				<b>25. DATE RECD. BY LOCAL REG.</b> <u>11-11-1959</u>		<b>25. REGISTRAR'S SIGNATURE</b> <u>Ruth B. Powell</u>		

MS DEC 2 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 Carl J. Palmer

Licensed Embalmer No. 2370

P. O. Address Palmdale

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.