DURI DIVISION OF HEALTH — STANDARD CERTIFICATE OF DEATH

FILED VS NOV 16 1959

59-041752

STATE FILE NUMBER

Registration District No. _____ Primary Registration District No. _____ Registrar's No. 2 9161

MENDED

1. PLACE OF DEATH
a. COUNTY

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Mo. b. COUNTY St. Louis

b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. LOUIS, MISSOURI
Length of stay in 1b: 4 Days

c. CITY OR TOWN Webster Groves
Inside Limits: Yes ☒ No ☐

c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION BARNES HOSPITAL
Inside Limits: Yes ☒ No ☐

d. STREET ADDRESS (If outside, give location) 812 Tuxedo
Reside on Farm: Yes ☐ No ☐

3. NAME OF DECEASED (Type or print) First: DWIGHT Middle: M. Last: DILLON

4. DATE OF DEATH Month: Oct. Day: 4 Year: 1959

5. SEX: M

6. COLOR OR RACE: W

7. Married ☒ Never Married ☐ Widowed ☐ Divorced ☐

8. DATE OF BIRTH: 8-4-1918

9. AGE (last birthday): 41

IF UNDER 1 YEAR: Months ____ Days ____ IF UNDER 24 HR: Hours ____ Min. ____

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Teacher

10b. KIND OF BUSINESS OR INDUSTRY: U.City H.S.

11. BIRTHPLACE (City and state or country): Salt Lake City Utah

12. CITIZEN OF WHAT COUNTRY: USA

13a. FATHER'S NAME: John Dillon

13b. MOTHER'S MAIDEN NAME: Celia Northey

14. NAME OF HUSBAND OR WIFE: Lynn Dillon

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes, give war or dates of service): W.W.# 2

16. SOCIAL SECURITY NO.: 529-09-9992

17. INFORMANT: Lynn Dillon Address: 812 Tuxedo

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Cerebral Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 5 days

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

DUE TO (b) _____

DUE TO (c) 332x

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. ☐ Yes ☐ No ☐ Unknown

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year

20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

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 Sept. 30, 1959, to Oct. 4, 1959 and last saw ~~xxx~~ him alive on Oct. 4, 1959

Death occurred at 5:55 A.M. m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE F.R. Bradley (Degree or title) M.D.

22b. ADDRESS BARNES HOSPITAL

22c. DATE SIGNED 10/4/59

23a. BURIAL, CREMATION, REMOVAL (Specify): Removal

23b. DATE: 10-7-1959

23c. NAME OF CEMETERY OR CREMATORY: Christian Cemetery

23d. LOCATION (City, town, or county) (State): Fredericktown Mo.

24. FUNERAL DIRECTOR ADDRESS: Parker-Aldrich Webster Groves Mo.

25. DATE RECD. BY LOCAL REG.: OCT 6 '59

26. REGISTRAR'S SIGNATURE: Earl Smith M.D.

(Licensed Embalmer's Statement on Reverse Side)

BY AFFIDAVIT OF DOCUMENT

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 Leslie Welch

Licensed Embalmer No. 4395

P. O. Address Webster Gro

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