

UNITED STATES DEPARTMENT OF HEALTH - STANDARD CERTIFICATE OF DEATH

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FILED VS DEC 29 1959 381

Registration District No. \_\_\_\_\_ Primary Registration District No. 6185 Registrar's No. 122

STATE FILE NUMBER

ENDED

1. PLACE OF DEATH a. COUNTY <b>Sullivan</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> COUNTY <b>Sullivan</b>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Union Twp.</b>		Length of stay in 1b <b>Life</b>		c. CITY OR TOWN <b>Milan</b>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>14 mi. SW Green City</b>				Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <b>14 mi. SW Green City</b>	
3. NAME OF DECEASED (Type or print) First <b>Francie</b> Middle <b>Jackson</b> Last <b>Dillinger</b>				4. DATE OF DEATH Month <b>Dec.</b> Day <b>19</b> Year <b>1959</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <b>4/3/1867</b>	
				9. AGE (last birthday) <b>92</b>		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) <b>Farmer</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>General Farming</b>			11. BIRTHPLACE (City and state or country) <b>Owasco, Missouri</b>	
						12. CITIZEN OF WHAT COUNTRY <b>USA</b>	
13a. FATHER'S NAME <b>John Dillinger</b>			13b. MOTHER'S MAIDEN NAME <b>Nancy Cleeton</b>			14. NAME OF HUSBAND OR WIFE <b>Eva Dillinger</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>			16. SOCIAL SECURITY NO. <b>None</b>			17. INFORMANT Address <b>Thomas J. Dillinger, Milan, Mo.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Serility</b>						INTERVAL BETWEEN ONSET AND DEATH <b>_____</b>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>Fracture L. femur</b>						<b>12-15-59</b>	
DUE TO (c) <b>fall in roadway</b>						<b>12-15-59</b>	
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 type="checkbox"/> No <input type="checkbox"/> Unknown	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT <input checked="" 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.) <b>Trip over loose gravel while walking from car to gate</b>			
20c. TIME OF INJURY Hour <b>6:00 a.m.</b> Month, Day, Year <b>12-15-59</b>							
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>Road at home</b>		20f. CITY, TOWN, OR LOCATION <b>Greencity, <sup>105</sup> Sullivan, Mo.</b>		COUNTY STATE	
21. I attended the deceased from <b>12-15-59</b> to <b>12-19-59</b> and last saw him alive on <b>12-19-59</b> Death occurred at <b>2:15</b> <b>PM</b> on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE <b>Ed Simpson, D.O.</b> (Degree or title)				22b. ADDRESS <b>MILAN, MO</b>		22c. DATE SIGNED <b>12-19-59</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>12/31/1959</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Owasco Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Sullivan County, Mo.</b>	
24. FUNERAL DIRECTOR ADDRESS <b>Glenn E. Kent &amp; Son, Green City, Mo.</b>				25. DATE RECD. BY LOCAL REG. <b>12-24-59</b>		26. REGISTRAR'S SIGNATURE <b>Mrs. M. W. Beckett</b>	

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

**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 Karl R. Zent

Licensed Embalmer No. 4689

P. O. Address Green City

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.