

FRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH
 FILED VS APR 4 1960

60-011691

Registration District No. 179 Primary Registration District No. 5667 Registrar's No. 48

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>Lincoln</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Lincoln</u>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Bedford</u>		Length of stay in 1b <u>4da.</u>		c. CITY OR TOWN <u>Winfield</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Lincoln County Memorial Hospital</u>			Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>6 Mi. west of Winfield Mo.</u>		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Ella</u> Middle <u>Maria</u> Last <u>Dillon</u>				4. DATE OF DEATH Month <u>Mar.</u> Day <u>22</u> Year <u>1960</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <u>Jan. 30, 1864</u>	9. AGE (last birthday) <u>96</u>	IF UNDER 1 YEAR Months <u>1</u> Days <u>22</u> Hours <u></u> Min. <u></u>	IF UNDER 24 HR Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Housework</u>		11. BIRTHPLACE (City and state or country) <u>Dover Tennessee</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13a. FATHER'S NAME <u>Wm. McGee</u>			13b. MOTHER'S MAIDEN NAME <u>Matilda Parker</u>		14. NAME OF HUSBAND OR WIFE <u>Murry Dillon</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO. <u></u>	17. INFORMANT Address <u></u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac exhaustion</u>						INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks</u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Obcess of throat</u>						<u>3 weeks</u>	
DUE TO (c) <u>Infirmities of age</u>							
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 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 <u></u> a.m. <u></u> p.m. <u></u>	Month <u></u> Day <u></u> Year <u></u>						
20d. INJURY OCCURRED WHILE AT WORK <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 <u>March 5</u> to <u>March 22, 1960</u> and last saw her <u>him</u> alive on <u></u> . Death occurred at <u></u> on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE <u>H. T. Kelley</u> (Degree or title) <u>D.O.</u>			22b. ADDRESS <u>Troy Mo</u>			22c. DATE SIGNED <u>May 25 60</u> (State)	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>March 24, 1960</u>	23c. NAME OF CEMETERY OR CREMATORY <u>New Galilee</u>		23d. LOCATION (City, town, or county) <u>Lincoln County Mo.</u>		
24. FUNERAL DIRECTOR <u>D. W. McCoy</u> ADDRESS <u>Troy Mo</u>				25. DATE RECD. BY LOCAL REG. <u>Mar. 28, 1960</u>		26. REGISTRAR'S SIGNATURE <u>Charlotte Leeker</u>	

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 _____
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed L. W. McCoy

Licensed Embalmer No. 358

P. O. Address Jay MO

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