

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **3990**

-61-015071
STATE FILE NUMBER

AMENDED

Registration District No. **318**
FILED MAY 4 1961

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		Length of stay in 1b	c. CITY OR TOWN St. Louis
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Firmin Desloge		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 3429 Park Ave
Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			

3. NAME OF DECEASED (Type or print) First John Middle Last Dillon	4. DATE OF DEATH Month Apr Day 24 Year 1961
--	---

5. SEX Male	6. COLOR OR RACE White	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 9/15/1899	9. AGE (last birthday) 61	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR Hours Min.
-----------------------	----------------------------------	---	--------------------------------------	-------------------------------------	---	------------------------------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Turnkey	10b. KIND OF BUSINESS OR INDUSTRY St. Louis Police Dept.	11. BIRTHPLACE (City and state or country) St. Louis Mo	12. CITIZEN OF WHAT COUNTRY USA
---	--	---	---

13a. FATHER'S NAME John J. Dillon	13b. MOTHER'S MAIDEN NAME Alice Cullen	14. NAME OF HUSBAND OR WIFE Bernice Stretch Dillon
---	--	--

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	16. SOCIAL SECURITY NO.	17. INFORMANT Bernice Dillon Address 3429 Park
---	-------------------------	---

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia		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) Arteriosclerotic Cardiovascular disease	
	DUE TO (c) 442x	

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 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 11:20 P Month, Day, Year June 15, 1957	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 St. Louis Mo.	COUNTY	STATE
--	--	--	--	--------	-------

21. I attended the deceased from June 15, 1957 to Apr 24, 1961 and last saw him alive on Apr 24, 1961 Death occurred at 11:20 P on the date stated above, and to the best of my knowledge, from the causes stated.	22a. SIGNATURE M. J. Thomas M.D.	22b. ADDRESS 3915 Watson Rd	22c. DATE SIGNED 4/26/61
---	--	---------------------------------------	------------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 4/28/61	23c. NAME OF CEMETERY OR CREMATORY Calvary	23d. LOCATION (City, town, or county) St. Louis Mo.	(State)
--	-----------------------------	--	---	---------

24. FUNERAL DIRECTOR E. J. Schnur ADDRESS 3125 Lafayette	25. DATE RECD. BY LOCAL REG. APR 26 1961	26. REGISTRAR'S SIGNATURE Loed Smith, M.D.
---	--	--

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
 DATE AMENDED
 INSTEAD OF
 DOCUMENT
 MEDICAL CERTIFICATION
 SHOULD READ
 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 Joseph B. Vollmer

Licensed Embalmer No. 11014

P. O. Address 3125 Lafayette

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.