LOCAL REGISTRAR'S REPORT—DO NOT TEAR LEAF OUT

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

13394

1. PLACE OF DEATH

County ..... Registration District No. 791 File No. .....

Township ..... Primary Registration District No. 1003 Registered No. 3721

City St. Louis (No. In Ambulance St. ..... Ward)

2. FULL NAME James C. Dillon

(a) Residence. No. 821 N. 15th St., 25 Ward. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): Single

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR): Unknown

7. AGE: Abt. 58 YEARS | MONTHS: — | DAYS: — | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Electrician
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Mo.

PARENTS
10. NAME OF FATHER: James Dillon
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY): Unknown
12. MAIDEN NAME OF MOTHER: Ellen Casey
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY): Unknown

14. INFORMANT: H. W. Fath
(Address) Coroner's Office

15. FILED APR 13 1927 19.. Max C. Starkloff REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): 4/15 1927

17. I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19.....
that I last saw h..... alive on ....., 19....., and that death occurred, on the date stated above, at 7-20 P. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
943 Coronary Thrombosis
W.M.A. (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) 92 (duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED?
IF NOT AT PLACE OF DEATH? .....
DID AN OPERATION PRECEDE DEATH? ..... DATE OF .....
WAS THERE AN AUTOPSY? Yes
WHAT TEST CONFIRMED DIAGNOSIS? .....

(Signed) H. W. Fath, M.D.
4/18, 1927 (Address) Deputy Coro

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL: Calvary Cem. | DATE OF BURIAL: Apr 19 1927

20. UNDERTAKER: Thos. J. Finan | ADDRESS: 1514 So Grand

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

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BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

1. PLACE OF DEATH

County..... Registration District No.....1..... File No.....4396.....

Township..... Primary Registration District No..... Registered No. .....

City..... (No....., ...St. .....Ward)

2. FULL NAME .....

(a) Residence. No..... St., ...Ward. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX | 4. COLOR OR RACE | 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word)

5A. IF MARRIED, WIDOWED, OR DIVORCED
HUSBAND OF
(OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

7. AGE | YEARS | MONTHS | DAYS | If LESS than 1 day, ...hrs. or .....min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work.....
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9. BIRTHPLACE (CITY OR TOWN) .....
(STATE OR COUNTRY)

PARENTS

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (CITY OR TOWN).....
(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (CITY OR TOWN).....
(STATE OR COUNTRY)

14.
INFORMANT .....
(Address)

15.
FILED....., 19..... .....
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 19

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I HEREBY CERTIFY, That I attended deceased from .....
....., 19....., to ....., 19.....
that I last saw h..... alive on....., 19....., and that death occurred, on the date stated above, at.....m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

.....
.....
.....
.....(duration).....yrs. .....mos.....ds.

CONTRIBUTORY.....
(SECONDARY)
.....(duration).....yrs. .....mos.....ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH?.....
DID AN OPERATION PRECEDE DEATH?..... DATE OF.....
WAS THERE AN AUTOPSY?.....
WHAT TEST CONFIRMED DIAGNOSIS?.....
(Signed)....., M. D
, 19 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL | DATE OF BURIAL 19

20. UNDERTAKER | ADDRESS

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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