

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

Do not use this space.

35070

1. PLACE OF DEATH

County..... Registration District No. **791**
 Township..... Primary Registration District No. **1003**
 City **St. Louis mo** (No. **2213**, **Randolph**)

File No.....
 Registered No. **19047**
 St. Ward)

2. FULL NAME

William Dillard
 (a) Residence. No. **2213 Randolph** St., **W** 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 **Cold** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) **married**
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF
 6. DATE OF BIRTH (MONTH, DAY AND YEAR) **1873-9-30**
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
35 0 9

8. OCCUPATION OF DECEASED
 (a) Trade, profession, or particular kind of work **Labourer 10¹**
 (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) **Missouri**

10. NAME OF FATHER **John Dillard**
 11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) **mo.**
 12. MAIDEN NAME OF MOTHER **Mary Thomas**
 13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) **mo.**

14. INFORMANT **Mary Bell Dillard**
 (Address) **2213 Randolph St.**

15. FILED **12 1923** **Maye Starceff** REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) **10-9-1928**
 17. I HEREBY CERTIFY That I attended deceased from **10-28**, 19**28**, to **10-9-1928**, and that I last saw him alive on **10-9-1928**, and that death occurred, on the date stated above, at **3:30 p.m.**

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Lobar Pneumonia
10100 (duration) yrs. mos. **2** ds.

CONTRIBUTORY (SECONDARY) **Lobar Pneumonia**
 (duration) yrs. mos. **2** ds.

18. WHERE WAS DISEASE CONTRACTED **Unknown**
 IF NOT AT PLACE OF DEATH:
 DID AN OPERATION PRECEDE DEATH? **no** DATE OF
 WAS THERE AN AUTOPSY? **no**
 WHAT TEST CONFIRMED DIAGNOSIS? **Symptoms**
 (Signed) **L. J. V. ...** M. D.
 (Address) **239th So. Jefferson**

*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.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL **Father Dickson** DATE OF BURIAL **Oct. 12th 1928**

20. UNDERTAKER **A. L. Beal** ADDRESS **2726 Lucas**

WRITE FULLY, 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.

