

FILED APR 18 1945

Registration District No. 72

Primary Registration District No. 1000

State File No. \_\_\_\_\_

Registrar's No. 397

1. PLACE OF DEATH:

(a) County Buchanan  
(b) City or town St. Joseph  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
St. Joseph's Hospital  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 5 1/2 Days (Hospital)  
(Specify whether  
In this community 45 Years  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Buchanan  
(c) City or town St. Joseph  
(If outside city or town limits, write "RURAL")  
(d) Street No. 2208 No. 2nd. St.  
(If rural, give location)  
(e) Citizen of foreign country? No. (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Arthur Carlyle Dill

3. (b) If veteran, name war None  
3. (c) Social Security No. None

4. Sex Male 5. Color or race White  
6. (a) Single, widowed, married, divorced Married  
6. (b) Name of husband or wife Anna M.  
6. (c) Age of husband or wife if alive 61 years  
7. Birth date of deceased June 11 1879  
(Month) (Day) (Year)

8. AGE: Years 65 Months 10 Days 2  
If less than one day  
hr. \_\_\_\_\_ min.

9. Birthplace Unknown Kansas  
(City, town, or county) (State or foreign country)

10. Usual occupation Mail Carrier

11. Industry or business U. S. Government

12. Name Henry J. Dill  
13. Birthplace Unknown Ohio  
(City, town, or county) (State or foreign country)  
14. Maiden name Susan B. Bruner  
15. Birthplace Unknown Ohio  
(City, town, or county) (State or foreign country)

16. (a) Informant Anna M. Dill  
(b) Address 2208 No. 2nd. St.

17. (a) Burial (b) Date thereof Apr. 17, 1945  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mt Olivet Cemetery

18. (a) Signature of funeral director Herman [Signature]  
(b) Address 1802 Union St., St. Joseph, Mo.

19. (a) April 14, 45 (b) [Signature]  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 13  
year 1945 hour 4 minute 30 P. M.

21. I hereby certify that I attended the deceased from July 15 1944 to Apr 13 1945  
that I last saw him alive on Apr. 13 1945  
and that death occurred on the date and hour stated above.

Immediate cause of death: Carcinoma of prostate (Primary)  
Duration 1 yr.

Due to \_\_\_\_\_  
Due to \_\_\_\_\_

Other conditions: Rel. Carcin. re. femur  
(Include pregnancy within 3 months of death)  
Lower spine

Major findings:  
Of operations \_\_\_\_\_  
Of autopsy none 5/14

PHYSICIAN  
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:  
(a) Accident, suicide, or homicide (specify) \_\_\_\_\_  
(b) Date of occurrence \_\_\_\_\_  
(c) Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)  
(d) Did injury occur in or about home, on farm, in industrial place, in public place? \_\_\_\_\_

(Specify type of place)  
While at work \_\_\_\_\_ (e) Means of injury None  
23. Signature Frank [Signature] (M. D. or other)  
Address 620 Bruce Date signed 4/14/45

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

JUN 22 1945

APR 20 1945

FEB 17 1947

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.....

....., Registered Apprentice No. ....

working under my personal supervision.

Signed Keith Collier

Licensed Embalmer No. 3632

P.O. Address St Joseph M

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 this body is not embalmed, fact should be so stated above.