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DEPARTMENT OF HEALTH
BUREAU OF VITAL RECORDS
FILED 001 8-18-46

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

30219

State File No. _____
Registrar's No. **4048**

Registration District No. **149** Primary Registration District No. **1002**

1. PLACE OF DEATH:

(a) County **Jackson**

(b) City or town **Kansas City**
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
641 West Dartmouth Road
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution **no.** (Specify whether)

In this community **4 years**
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Jackson** **48**

(c) City or town **Kansas City** **3**
(If outside city or town limits, write "RURAL")

(d) Street No. **641 West Dartmouth Road,** **8**
(If rural, give location)

(e) Citizen of foreign country? **no.** (Yes or No)

If yes, name country **X**

3. (a) PRINT FULL NAME **Clarence O. Dillard**

3. (b) If veteran, name war **no.** 3. (c) Social Security No. **512-18-4066**

4. Sex **male** 5. Color or race **white**

6. (a) Single, widowed, married, divorced **married**

6. (b) Name of husband or wife **Mrs. Linnie Dillard** 6. (c) Age of husband or wife if alive **47** years

7. Birth date of deceased **April 18 1885**
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
61	5	7	hr. min.

9. Birthplace **Nebraska**
(City, town, or county) (State & foreign country)

10. Usual occupation **Retired**

11. Industry or business **X**

12. Name **George William Dillard**

13. Birthplace **Kentucky**
(City, town, or county) (State or foreign country)

14. Maiden name **Carrie Ottman**

15. Birthplace **New York**
(City, town, or county) (State or foreign country)

16. (a) Informant **Mrs. Linnie Dillard,**
(b) Address **641 W. Dartmouth Road, K. C., Mo.**

17. (a) **removal** (b) Date thereof **9-25-46**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Denver, Colorado.**

18. (a) Signature of funeral director **Stine & McClure,**
(b) Address **3235 Gillham Plaza, K. C., Mo.**

19. (a) **9-25-46** (b) **Gertrudine Holman**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **September** day **25**
year **1946** hour **6:50** minute **A.** M.

21. I hereby certify that I attended the deceased **from** **ON**
9-25 19 **46** to **9-25** 19 **46**
that I last saw h. **alive** on **9-25** 19 **46**
and that death occurred on the date and hour stated above.

Immediate cause of death **Coronary Thrombosis**

Due to _____

Due to _____

Other conditions **None known**
(Include pregnancy within 3 months of death)

Major findings: **None Performed**

Of operations **None Performed**

Of autopsy **None Performed**

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? _____

While at work? _____ (e) Means of injury **0**

23. Signature **William B. Allen** (M. D. or other)
Address **Professional Bldg** Date signed **9-25-46**
Kansas City Mo

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

Dr. Stanley Morest

Woff Blodg

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..... *Robert H. Reed*

Licensed Embalmer No. *3745*

P. O. Address..... *Mc. Mo*

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.