

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **24740**
Registrar's No. **5889**

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

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, write RURAL and give township) OR TOWN St. Louis	c. LENGTH OF STAY (in this place) <input checked="" type="checkbox"/>	c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis	
d. FULL NAME OF HOSPITAL OR INSTITUTION City Hospital		d. STREET ADDRESS (If rural, give location) 7-6335 Amelia Ave.	

3. NAME OF DECEASED (Type or Print) Frank H. Dilla			4. DATE OF DEATH (Month) (Day) (Year) 7 5-1949		
--	--	--	---	--	--

5. SEX male	6. COLOR OR RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married	8. DATE OF BIRTH Nov. 12th 1889	9. AGE (In years last birthday) 59	IF UNDER 1 YEAR Months	IF UNDER 1 YEAR Days	IF UNDER 1 HRS. Hours	IF UNDER 1 HRS. Min.
--------------------	-------------------------------	---	--	---	---------------------------	-------------------------	--------------------------	-------------------------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired Butcher		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Indiana		12. CITIZEN OF WHAT COUNTRY?	
--	--	-----------------------------------	--	--	------------------------------	--

13a. FATHER'S NAME Fred Dilla		13b. MOTHER'S MAIDEN NAME Elizabeth Smith		14. NAME OF HUSBAND OR WIFE Emma Dilla	
--------------------------------------	--	--	--	---	--

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) none	16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME ADDRESS Emma Dilla 6335 Amelia Ave.			
--	-------------------------	--	--	--	--

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) <i>*This does not mean the mode of dying, such as heart failure, assthenia, etc. It means the disease, injury, or complication which caused death.</i>	MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Hemorrhage due to gun shot wound of head self inflicted at his home on July 5 1949			INTERVAL BETWEEN ONSET AND DEATH
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) self inflicted at his home on July 5 1949			
	DUE TO (c) about 1000 pm			
	II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION Suicide		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
------------------------	---	--	---	--

21a. ACCIDENT SUICIDE (Specify) Suicide	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Home	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) St. Louis Mo. Mo.
--	--	--

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) July 5 49 1000	21e. INJURY OCCURRED WHILE AT <input type="checkbox"/> WORK <input type="checkbox"/> NOT WHILE AT WORK	21f. HOW DID INJURY OCCUR? E976X
---	--	---

22. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at **3:20 P** m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Patrick C Taylor Coroner		23b. ADDRESS 313.00 Clark	23c. DATE SIGNED 7-6-49
--	--	----------------------------------	--------------------------------

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 7-9-1949	24c. NAME OF CEMETERY OR CREMATORY Valhalla Cemetery	24d. LOCATION (City, town, or county) (State) St. Louis County Mo
---	---------------------------	---	--

DATE REC'D BY LOCAL REG. JUL 6 1949	REGISTRAR'S SIGNATURE J. B. Loater	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Hy. Leidner U. 2223 St. Louis Ave.	
--	---	--	--

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

144

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.

Signed Clement M. Neary

Signed _____
Student Embalmer

Licensed Embalmer No. 3732

P. O. Address St. Louis 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.