

FILED FEB 12 1951

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 1696

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 175 PRIMARY REG. DIST. NO. 3036 Registrar's No. 13

1. PLACE OF DEATH a. COUNTY Lawrence		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Lawrence	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Aurora		c. LENGTH OF STAY (in this place) 62 yr.	
d. FULL NAME OF HOSPITAL OR INSTITUTION 610 Madison St.		d. STREET ADDRESS (If rural, give location) 610 Madison St.	
3. NAME OF DECEASED (Type or Print) Fannie Price Dillard			4. DATE OF DEATH Feb. 4, 1951
5. SEX F	6. COLOR OR RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED Widowed	8. DATE OF BIRTH Dec 5, 1861
9. AGE (In years last birthday) 89		10. UNDER 1 YEAR Months	10. UNDER 1 YEAR Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife		10b. KIND OF BUSINESS OR INDUSTRY house wife	11. BIRTHPLACE (State or foreign country) Polk Co. Missouri
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13a. FATHER'S NAME Dr. Samuel Neal	
13b. MOTHER'S MAIDEN NAME Melsie Rountree		14. NAME OF HUSBAND OR WIFE Ben W. Dillard	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. No	17. INFORMANT'S SIGNATURE OR NAME Harry Dillard
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <i>cerebral thrombosis</i> ANTECEDENT CAUSES <i>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.</i> DUE TO (b) _____ DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS <i>Conditions contributing to the death but not related to the disease or condition causing death.</i>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		21. INTERVAL BETWEEN ONSET AND DEATH 1 day.	
21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from _____, 1951, to Feb 4, 1951, that I last saw the deceased alive on Feb 3, 1951; and that death occurred at 5:00 P.M., from the causes and on the date stated above.			
23a. SIGNATURE <i>A. P. Lopez M.P.O.</i> (Degree or title)		23b. ADDRESS Aurora, Mo	23c. DATE SIGNED 2-5-51
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE Feb. 7, 1951	24c. NAME OF CEMETERY OR CREMATORY Danforth Cemetery	24d. LOCATION (City, town, or county) (State) Green Co. Missouri
DATE REC'D BY LOCAL REG. FEB 6, 51	REGISTRAR'S SIGNATURE <i>Oral Mc Natt</i>	25. FUNERAL DIRECTOR'S SIGNATURE William Wood	ADDRESS Aurora, Mo.

(Licensed Embalmer's Statement on Reverse Side)

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

DIVISION OF HEALTH OF MO.  
District No. 5 - Springfield

RECEIVED FEB 10 1951

Dist. File 221-343

Date Fil. 2-10-51

JAN 26 1951

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 \_\_\_\_\_

working under my personal supervision.

Student Embalmer No. \_\_\_\_\_

Signed \_\_\_\_\_  
Student Embalmer

Signed James D. Crafton

Licensed Embalmer No. 4668

P. O. Address Aurora, 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.