

FILED OCT 10 1951

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **31418**  
Registrator's No. **8523**

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).	
b. CITY (If outside corporate limits, write RURAL and give township) TOWN <b>St. Louis</b>		a. STATE <b>Missouri</b> b. COUNTY	
c. LENGTH OF STAY (in this place) <b>39 yrs</b>		c. CITY (If outside corporate limits, write RURAL and give township) TOWN <b>St. Louis</b> <b>2229</b>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>Homer G Phillips Hospital</b>		d. STREET ADDRESS (If rural, give location) <b>222 211 S 22nd Street</b> <b>0</b>	

3. NAME OF DECEASED (Type or Print)		4. DATE OF DEATH	
a. (First) <b>Watson</b>	b. (Middle)	c. (Last) <b>Dillard</b>	(Month) (Day) (Year) <b>Sept. 24 1951</b>
5. SEX <b>Male 2</b>	6. COLOR OR RACE <b>Colored</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Separated 1</b>	8. DATE OF BIRTH <b>7-18-1876</b>
9. AGE (In years last birthday) <b>75</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Nil</b>	11. BIRTHPLACE (State or foreign country) <b>Georgia /</b>
10a. USUAL OCCUPATION		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	

13a. FATHER'S NAME <b>Howard Dillard</b>	13b. MOTHER'S MAIDEN NAME <b>Elizabeth Moses</b>	14. NAME OF HUSBAND OR WIFE <b>None</b>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Not known ?</b>	16. SOCIAL SECURITY NO. <b>?</b>	17. INFORMANT'S SIGNATURE OR NAME <b>Elizabeth Rhodes, 2601 N Whittier St</b>	ADDRESS
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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, asphyxia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH <b>2 months</b>
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Cerebral Thrombosis</b>		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <b>Arteriosclerotic Heart Disease</b> DUE TO (c) <b>Generalized Arteriosclerosis</b>		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <b>None</b>			

19a. DATE OF OPERATION <b>None</b>	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify) <b>No</b>	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? <b>H200</b>
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22. I hereby certify that I attended the deceased from **8-9**, 19 **51**, to **9-24**, 19 **51** that I last saw the deceased alive on **9-24**, 19 **51**, and that death occurred at **3:30p m.**, from the causes and on the date stated above.

23a. SIGNATURE <b>W H Simbler</b>	(Degree or title) <b>M. D.</b>	23b. ADDRESS <b>2601 N Whittier St</b>	23c. DATE SIGNED <b>9-24-51</b>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <b>6</b>	24b. DATE <b>SEP 26 1951</b>	24c. NAME OF CEMETERY OR CREMATORY <b>Anatomical Board</b>	24d. LOCATION (City, town, or county) (State)
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DATE REC'D BY LOCAL REG. <b>SEP 26 1951</b>	REGISTRAR'S SIGNATURE <b>J. Carl Smith MD Rowland</b>	25. FUNERAL DIRECTOR'S SIGNATURE <b>4104 Manchester</b>	ADDRESS
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**m 83** (Licensed Embalmer's Statement on Reverse Side)

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

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**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.

Student .....  
Student Embalmer

Signed.....

Licensed Embalmer No.....

P. O. Address.....

**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.**