

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **17948**

FILED JUL 5 - 1955

BIRTH NO. _____ REG. DIST. NO. **53** PRIMARY REG. DIST. NO. **3010** Registrar's No. **271**

1. PLACE OF DEATH CAPE GIRARDEAU a. COUNTY Jackson		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Ill COUNTY Alayander	
b. CITY (If outside corporate limits, write RURAL and give township) Cape Girardeau	c. LENGTH OF STAY (In this place) 10 days	c. CITY (If outside corporate limits, write RURAL and give township) Caro	
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Francis Hosp		d. STREET ADDRESS (If rural, give location) 2601 - Park Ave 8120 8	

3. NAME OF DECEASED (First) Charles		b. (Middle) E		c. (Last) Dille		4. DATE OF DEATH (Month) (Day) (Year) June 26 85	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married		8. DATE OF BIRTH May 16, 1879		9. AGE (In years last birthday) 76 IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work during most of working life, even if retired) Doctor		10b. KIND OF BUSINESS OR INDUSTRY Veterinary		11. BIRTH PLACE (State or foreign country) Villa Ridge Ill		12. CITIZEN OF WHAT COUNTRY? U.S.A.	

13a. FATHER'S NAME James W. Dille		13b. MOTHER'S MAIDEN NAME Jane Davidson		14. NAME OF HUSBAND OR WIFE Mary P. Dille			
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) no		16. SOCIAL SECURITY NO. None		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Mary P. Dille Caro Ill			
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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, ashenia, etc. It means the disease, injury, or complication which caused death.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cardiac Failure		INTERVAL BETWEEN ONSET AND DEATH 3 d
	ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Hypertensive Heart Disease		
	DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Collapse after prostate surgery			

19a. DATE OF OPERATION 6-24-55		19b. MAJOR FINDINGS OF OPERATION BPH		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
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) (Min.)		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 **6-20, 1955**, to **6-26, 1955**, that I last saw the deceased alive on **6-26, 1955**, and that death occurred at **3:59** m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) [Signature]		23b. ADDRESS 219 N Pacific Top Gun		23c. DATE SIGNED 7-1-55	
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24a. BURIAL, CREMATION, REMOVAL (Specify) Buried		24b. DATE June 28-55		24c. NAME OF CEMETERY OR CREMATORY Thistlewood Cemetery		24d. LOCATION (City, town, or county) (State) Mounds Ill	
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DATE REC'D BY LOCAL REG. 7-2-55		REGISTRAR'S SIGNATURE [Signature]		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Frank A. Kacher Caro Ill	
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

MAR 6 1963

JUL 6 1955

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 Frank A. Karcher

Licensed Embalmer No. 2103

P. O. Address Paris Ill

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.