

XC 1481 28 56
Reg. 13057

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

41988

State File No.

FILED JAN 6 1956 318

REG. DIST. NO. 1003 PRIMARY REG. DIST. NO. 1003 Registrar's No. 11212

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE MISSOURI b. COUNTY Franklin	
b. CITY (If outside corporate limits, write RURAL and give OR TOWN 915 N. Grand St. Louis, Mo.)		c. CITY OR TOWN UNION	d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. LENGTH OF STAY (In this place) 6 Days		e. STREET ADDRESS (If rural, give location) ROUTE 1	
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION Veterans Administration Hospital			
3. NAME OF DECEASED (Type or Print) a. (First) LOUIS		b. (Middle) J.	c. (Last) DILL
4. DATE OF DEATH 12-21-55		5. SEX MALE <input checked="" type="checkbox"/>	
6. COLOR OR RACE WHITE		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Never married	8. DATE OF BIRTH 7-2-89
9. AGE (In years last birthday) 66 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer	10b. KIND OF BUSINESS OR INDUSTRY Farming
11. BIRTHPLACE (City and State or Foreign Country) e Union, Missouri		12. CITIZEN OF WHAT COUNTRY? USA	
13a. FATHER'S NAME JOHN DILL		13b. MOTHER'S MAIDEN NAME ANNIE FRESH	14. NAME OF HUSBAND OR WIFE (NONE)
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WW-1		16. SOCIAL SECURITY NO. None	17. INFORMANT'S SIGNATURE OR NAME VA HOSPITAL St. Louis 6, Missouri
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) COR PULMONALE DUE TO CHRONIC PULMONARY EMPHYSEMA		INTERVAL BETWEEN ONSET AND DEATH UNK.	
*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.		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	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT SUICIDE HOMICIDE (Specify) NONE		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) V.A. 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 12-15 1955, to 12-21-1955, (If you were not present, state date of death) and that death occurred at 9:05 a.m., from the causes and on the date stated above.			
23a. SIGNATURE (Degree or title) H. P. Westphalinger M.D.		23b. ADDRESS VAH, St. Louis 6, Missouri	23c. DATE SIGNED 12-21-55
24a. LOCAL REG. DATE REC'D BY LOCAL REG. DEC 22 1955		24b. DATE 12-21-55	24c. NAME OF CEMETERY OR CREMATORY Union Mo
24d. LOCATION (City, town, or county) (State)		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Albert H. Hoppe 4700 Washington	

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

(Licensed Embalmer's Statement on Reverse Side)

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.....
Signature of Student Embalmer

Signed *J. Wm. Dinsley*
Licensed Embalmer No. *369*
P. O. Address *St. Louis*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.