

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-031182
STATE FILE NUMBER

Registration District No. 317 Primary Registration District No. 541 Registrar's No. 2193

1. PLACE OF DEATH a. COUNTY <u>ST LOUIS</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MISSOURI</u> COUNTY <u>ST LOUIS</u>	
b. CITY (If outside corporate limits, use townships only) OR TOWN <u>ELMWOOD</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>ELMWOOD 4390</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>ST LOUIS CITY HOSP.</u>		Length of stay in lb <u>7 DAYS</u>	d. STREET ADDRESS (If outside, give location) <u>9722 Meeks</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>Samuel</u> Middle <u>Dillon</u> Last <u>Dillon</u>			4. DATE OF DEATH Month <u>8</u> Day <u>18</u> Year <u>1958</u>		
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5. SEX <u>MALE</u>	6. COLOR OR RACE <u>colored</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JAN 17 1874</u>	9. AGE (In years last birthday) <u>83</u>	IF UNDER 1 YEAR Months <u>7</u> Days <u>1</u>	IF UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LABORER</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>UNK.</u>	11. BIRTHPLACE (City and state or country) <u>ST LOUIS MO</u>	12. CITIZEN OF WHAT COUNTRY? <u>MO</u>
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13a. FATHER'S NAME <u>SAMUEL DILLON</u>	13b. MOTHER'S MAIDEN NAME <u>ANNIE YANCY</u>	14. NAME OF HUSBAND OR WIFE <u>SPIRA DILLON</u>
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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) <u>No</u>	16. SOCIAL SECURITY NO. <u>UNK.</u>	17. INFORMANT <u>Spira Dillon</u> Address <u>9722 Meeks</u>
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Brain stem Hemorrhage.</u>		INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause lost.	DUE TO (b) <u>Chronic Lymphocyte Leukemia</u>	
	DUE TO (c) <u>204.0</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		19. WAS AUTOPSY PERFORMED? 1 YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>

20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
20c. TIME OF INJURY Hour <u>3:00</u> Month, Day, Year <u>8-18-58</u> a.m. <u>0</u> p.m. <u>0</u>	

20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION <u>ST. LOUIS</u>	COUNTY <u>ST. LOUIS</u>	STATE <u>MO</u>
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21. I attended the deceased from 8-11-1958 to 8-18-1958 and last saw him alive on 8-18-1958
Death occurred at 3:00 p.m. on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>Roger Christensen M.D.</u> (Degree or title)	22b. ADDRESS <u>601 S. Brentwood Blvd.</u>	22c. DATE SIGNED
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23a. REMOVAL (Specify)	23b. DATE <u>8-25-58</u>	23c. NAME OF CEMETERY OR CREMATORIUM <u>WASHINGTON PARK</u>	23d. LOCATION (City, town, or county) (State) <u>ST. LOUIS CITY MO</u>
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24. FUNERAL DIRECTOR <u>A. F. WALTON</u> ADDRESS <u>2707 Stoddard</u>	25. DATE RECD. BY LOCAL REG. <u>8-22-58</u>	26. REGISTRAR'S SIGNATURE <u>Herbert J. Donke M.D.</u>
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USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

All diseases in Part I must be causally related.

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 *Arthur L. Holliard*

Licensed Embalmer No. *4221*
P. O. Address *3100 Eastway*

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.