

**DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**

**59-024605**

**FILED VS AUG 11 1959**

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar's No. **59-58** STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <b>Dade</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo.</b> b. COUNTY <b>Dade</b>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>North twp.</b>		Length of stay in 1b <b>35 years</b>	c. CITY OR TOWN <b>Greenfield</b>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF HOSPITAL OR INSTITUTION <b>8mi. N. of Greenfield</b>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>Star Route #1</b>		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Walter</b> Middle <b>-</b> Last <b>Dill</b>			4. DATE OF DEATH Month <b>Aug.</b> Day <b>1</b> Year <b>1959</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <b>9-20-1883</b>	9. AGE (last birthday) <b>75</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farm</b>	11. BIRTHPLACE (City and state or country) <b>Dade County, Mo.</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>	
13a. FATHER'S NAME <b>John Dill</b>		13b. MOTHER'S MAIDEN NAME <b>Rosa Moore</b>		14. NAME OF HUSBAND OR WIFE <b>Audra Dill</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	17. INFORMANT <b>Mrs. Audra Dill; Greenfield, Mo.</b>		Address <b>Star Rt. #1</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Apoplexy</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.) DUE TO (b) _____ DUE TO (c) _____					INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)					PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" 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 _____ a.m. _____ p.m.	Month, Day, Year					
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION		COUNTY	STATE	
21. I attended the deceased from <b>1957</b> to <b>8-1-59</b> and last saw him alive on <b>7-27-59</b> Death occurred at <b>3:30</b> <b>p.m.</b> on the date stated above, and to the best of my knowledge, from the causes stated.						
22a. SIGNATURE (Degree or title) <b>J. C. Cowan M.D.</b>			22b. ADDRESS <b>Greenfield, Mo.</b>		22c. DATE SIGNED <b>8-2-59</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>Aug. 3, 1959</b>	23c. NAME OF CEMETERY OR CREMATORIUM <b>Greenfield Cem.</b>		23d. LOCATION (City, town, or county) (State) <b>Greenfield, Mo.</b>		
24. FUNERAL DIRECTOR <b>J. C. Canada; Greenfield, Mo.</b>		ADDRESS	25. DATE RECD. BY LOCAL REG. <b>Aug. 2, 1959</b>	26. REGISTRAR'S SIGNATURE <b>J. C. Canada</b>		

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by \_\_\_\_\_ or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_ working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed J. C. Canada  
Licensed Embalmer No. 4196

P. O. Address Greenfield

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to do so 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.