

URI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-008128

FILED VS FEB 18 1960

Registration District No. _____ Primary Registration District No. _____ Registrar No. **1243** STATE FILE NUMBER

UNDECEASED

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MO. b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. LOUIS		Length of stay in 1b	c. CITY OR TOWN ST. LOUIS
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION DEPAUL HOSPITAL		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 4514 FAIR
			Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First FRANK Middle L. Last DILLON			4. DATE OF DEATH Month FEB. Day 2, Year 1960		
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5. SEX MALE	6. COLOR OR RACE WHITE	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 11-7-1915	9. AGE (last birthday) 44	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) INSPECTOR	10b. KIND OF BUSINESS OR INDUSTRY MEAT	11. BIRTHPLACE (City and state or country) ST. LOUIS, MO.	12. CITIZEN OF WHAT COUNTRY U S A
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13a. FATHER'S NAME DAVID DILLON	13b. MOTHER'S MAIDEN NAME MARY JULIA CAVAUGHNAUGH	14. NAME OF HUSBAND OR WIFE MARYELLEN DILLON
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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) YES WORLD WAR # 2	16. SOCIAL SECURITY NO.	17. INFORMANT Address MARYELLEN DILLON 4514 a FAIR AVE
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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:		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Massive pulmonary artery thrombosis	1 hour
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) Unknown cause	
	DUE TO (c) 465x	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Chronic atherosclerotic bronchitis	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
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19. WAS AUTOPSY PERFORMED? 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.)
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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 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 _____
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21. I attended the deceased from September 1, 1959 to February 2, 1960 and last saw him alive on February 1, 1960 Death occurred at 12:40 a.m. on the date stated above, and to the best of my knowledge, from the causes stated.
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22a. SIGNATURE (Degree or title) John T. Lewton, M.D.	22b. ADDRESS 634 N. Grand Blvd.	22c. DATE SIGNED Feb. 2, 1960
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23a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL	23b. DATE 2/4/60	23c. NAME OF CEMETERY OR CREMATORY NATIONAL CEMETERY	23d. LOCATION (City, town, or county) (State) JEFFERSON BARRACKS MISSOURI
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24. FUNERAL DIRECTOR STROOT - CARROLL 4600 NATURAL BRIDGE	25. DATE RECD. BY LOCAL REG. FEB 3 1960	26. REGISTRAR'S SIGNATURE Earl Smith, M.D.
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(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

2nd
John Lawton
Age 3-30-76
Municipal
12/30/76

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 M W Rueter

Licensed Embalmer No. 4865

P. O. Address St Louis 8

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.