

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-042149

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 107 Primary Registration District No. 3019 Registrar's No. 204

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

FILED DEC 5 1962

VS 300
Rev. 4/59

6355

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY DUNKLIN		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY New Madrid	
b. CITY (If outside corporate limits, give TOWNSHIP only) Kennett		Length of stay in 1b 3 weeks	c. CITY OR TOWN Tallapoosa
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Dunklin Co. Memorial		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) Tallapoosa
3. NAME OF DECEASED (Type or print) First DONA Middle _____ Last DILLINGER		4. DATE OF DEATH Month NOVEMBER Day 21 Year 1962	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH Aug. 9, 1878
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House work		10b. KIND OF BUSINESS OR INDUSTRY EQUALITY, ILL.	9. AGE (last birthday) 84 yrs
11. BIRTHPLACE (City and state or country) U.S.A.		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13a. FATHER'S NAME TOM GOODSON		13b. MOTHER'S MAIDEN NAME BETTY CARNARD	
14. NAME OF HUSBAND OR WIFE JOHN DILLINGER (dec)		17. INFORMANT IDA BARKER (dau)	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. unknown	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis		INTERVAL BETWEEN ONSET AND DEATH 3 weeks	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Cerebral Arteriosclerosis		20 years	
DUE TO (c) Generalized Arteriosclerosis		unknown	
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 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 Nov 2 1962 to Nov 24th 1962 and last saw her alive on Nov 24, 1962 Death occurred at 3:00 <input type="checkbox"/> a.m. <input checked="" type="checkbox"/> p.m. on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE Charles R. Cook M.D.		22b. ADDRESS Kennett Mo	
22c. DATE SIGNED 11/28/62			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE 11-26-1962	23c. NAME OF CEMETERY OR CREMATORY STANFIELD CEMETERY	23d. LOCATION (City, town, or county) (State) CLARKTON, MISSOURI
24. FUNERAL DIRECTOR DAY & KNIGHT FUNERALHOME, MALDEN, MO.		25. DATE RECD. BY LOCAL REG. 11-30-1962	26. REGISTRAR'S SIGNATURE Carl Hershman

USE BLACK INK OR TYPEWRITER RIBBON

2025 FEB 15

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. J. Schuman

Licensed Embalmer No. 4086

P. O. Address Malden, Mo.

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.