

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

**63-020783**  
STATE FILE NUMBER

Registration District No. 209 Primary Registration District No. 3043 Registrar's No. 182

**FILED JUN 4 1963**

DO NOT WRITE ON THIS STUB

AMENDED

VS 300  
Rev. 4/59

1 0648

2 0648

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4 0

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12 2-0

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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 <u>Marion</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>Marion</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) <u>Hannibal</u> Length of stay in 1b <u>5 yrs</u>		c. CITY OR TOWN <u>Hannibal</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital give location) <u>St. Elizabeth Hosp</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>741 Clifford St</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Frank M. Dillman</u>		4. DATE OF DEATH Month Day Year <u>July 22, 1963</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>Apr 15, 1908</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Maan</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Boeing Air Craft Works, Mo</u>	11. BIRTHPLACE (City and state or country) <u>U.S.A.</u>
12a. FATHER'S NAME <u>David S. Dillman</u>		13b. MOTHER'S MAIDEN NAME <u>Sarah L. Stephenson Ruth Dillman</u>	
14. NAME OF HUSBAND OR WIFE <u>Ruth Dillman</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of war) <u>Yes WW2</u>	
16. SOCIAL SECURITY NO. <u>399 Edna Cox</u>		17. INSURANT Address <u>Hannibal, Mo</u>	
18. CAUSE OF DEATH (Enter only one cause per time for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>myocardial infarct</u> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH <u>30 min</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>P.O. Bleeding Dues ulcer</u>		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 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 Month, Day, Year a.m. p.m.	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 <u>4/26/63</u> to <u>5/22/63</u> and last saw her alive on <u>5/22/63</u> Death occurred at <u>6:40 AM</u> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>R M Shroy MD</u>		22b. ADDRESS <u>711 Grand Ave. Hannibal, Mo.</u>	22c. DATE SIGNED <u>5/23/63</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>May 25, 63</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet Cem. Hannibal, Mo</u>	
23d. LOCATION (City, town, or county) (State) <u>Hannibal, Mo</u>		25. DATE RECD. BY LOCAL REG. <u>May 23, 1963</u>	
26. REGISTRAR'S SIGNATURE <u>Dr. E. M. Lucke by Lillian M. Norman</u>		26. REGISTRAR'S SIGNATURE	

USE BLACK INK OR TYPEWRITER RIBBON

**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

*Raymond G. Clark*

Licensed Embalmer No. 4217

P. O. Address Hammond, 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.

*Permit issued 5/23/60*