U. S. No. 2
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 28969

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 8094

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:
(a) County
(b) City or town [illegible] Hospital St. Louis Mo (If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Barnes Hospital (If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 77 days In this community (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County St. Francois
(c) City or town Cantwell (If outside city or town limits, write "RURAL")
(d) Street No. (If rural, give location) NR
(e) Citizen of foreign country? (Yes or No) If yes, name country

3. (a) PRINT FULL NAME Charles Dillard
3. (b) If veteran, name war Nil
3. (c) Social Security No. Unknown
4. Sex Male
5. Color or race White
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Minnie May Dillard
6. (c) Age of husband or wife if alive 52 years
7. Birth date of deceased July (Month) 29 (Day) 1893 (Year)
8. AGE: Years 52 Months 1 Days 15 If less than one day hr. min.
9. Birthplace Shannon County (City, town, or county) Missouri (State or foreign country)
10. Usual occupation Farmer
11. Industry or business
FATHER 12. Name Efru Dillard
13. Birthplace Unknown (City, town, or county) Unknown (State or foreign country)
MOTHER 14. Maiden name Manda Randolph
15. Birthplace Unknown (City, town, or county) Unknown (State or foreign country)
16. (a) Informant Mrs. Nora May Hedgecoth
(b) Address Flat River, Missouri
17. (a) Removal (Burial, cremation, or removal) (b) Date thereof 9-15-45 (Month) (Day) (Year)
(c) Place: burial or cremation Desloge, Missouri
18. (a) Signature of funeral director Albert H. Hoppe
(b) Address 4700 Washington Blvd.
19. (a) SEP 17 1945 (Date received local registrar) (b) J. T. Bredeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month September day 14 year 1945 hour 9 minute 07 P. M.
21. I hereby certify that I attended the deceased from June 30, 1945, to September 14, 1945, that I last saw him alive on September 14, 1945, and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death multiple lung abscesses	2
Due to	
Due to	
Other conditions Brain abscess (Include pregnancy within 3 months of death)	2
Major findings: Of operations	
Of autopsy [illegible]	

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify)
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)
While at work? (e) Means of injury
23. Signature F. R. Bradley (M. D. ~~or other~~)
Address Barnes Hospital, Date signed 9/15/45

(Licensed Embalmer's Statement on Reverse Side)

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 ....

...., Registered Apprentice No..............................,

working under my personal supervision.

Signed John Ogonoski

Licensed Embalmer No. 3398

P. O. Address..............................

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 this body is not embalmed, fact should be so stated above.