

FILED AUG 1 1940

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 29988

Registration District No. 875

Primary Registration District No. 6162

Registrar's No. 168

1. PLACE OF DEATH:

(a) County Vernon Washington  
(b) City or town Nevada  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
State Hospital No 3  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 5 months  
(Specify whether  
In this community Not known  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Berry  
(c) City or town Cassville, mo  
(If outside city or town limits, write "RURAL")  
(d) Street No. Not known  
(If rural, give location)  
(e) If foreign born, how long in U. S. A. ? \_\_\_\_\_ years.

8. (a) PRINT FULL NAME SILAS ARCHIE AUTRY

3. (b) If veteran, name war \_\_\_\_\_ 8. (c) Social Security No. Not known

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Ann 6. (c) Age of husband or wife if alive Not known years

7. Birth date of deceased March 25 1909  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
31 3 17 hr. \_\_\_\_\_ min.

9. Birthplace Washington mo  
(City, town, or county) (State or foreign country)

10. Usual occupation Baker

11. Industry or business \_\_\_\_\_

12. Name S. M. Autry

13. Birthplace Not known  
(City, town, or county) (State or foreign country)

14. Maiden name Lana Hadlock

15. Birthplace Not known mo  
(City, town, or county) (State or foreign country)

16. (a) Informant State Hospital No 3 Records

(b) Address Nevada, mo

17. (a) Burial (b) Date thereof July 15, 1940  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Cassville, Mo.

18. (a) Signature of funeral director Ferry Funeral Home

(b) Address Nevada, Mo

19. (a) 7-14-40 (b) Allen V. Hayes  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 12 year 1940 hour 6 minute 15 P.M.

21. I hereby certify that I attended the deceased from February 11 1940, to July 12 1940 that I last saw him alive on July 12 1940; and that death occurred on the date and hour stated above.

Immediate cause of death Luetic meningio Encephalitis

Due to \_\_\_\_\_  
Due to \_\_\_\_\_

Other conditions Syphilitic epilepsy  
(Include pregnancy within 6 months of death)

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

Major findings:  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) \_\_\_\_\_  
(b) Date of occurrence \_\_\_\_\_

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? Yes

While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury \_\_\_\_\_

23. Signature G. S. Warwick (M. D. or other) 1  
Address State Hospital No 3 Nevada Date signed 7/12/40

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

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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 Personal

....., Registered Apprentice No. ....  
working under my personal supervision.

Signed Lloyd R. Winscott

Licensed Embalmer No. 3857

P. O. Address Spewady 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 this body is not embalmed, above space should be left blank.**