

MAR 25 1941

Registration District No. 263

Primary Registration District No. 6137

1. PLACE OF DEATH:

(a) County Texas
(b) City or town Rural Pinery
(c) Name of hospital or institution: 1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 6.0
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Texas
(c) City or town Rural
(If outside city or town limits, write "RURAL")
(d) Street No. 97 miles West Houston
(If rural, give location)
(e) If foreign born, how long in U. S. A.? 0 years.

8. (a) PRINT FULL NAME HANNAH ANN SILLYMAN

8. (b) If veteran, name war _____ 3. (c) Social Security No. NONE

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

6. (b) Name of husband or wife John Sillyman 6. (c) Age of husband or wife if alive 70 years
Birth date of deceased Feb 14 1870
(Month) (Day) (Year)

8. AGE: Years 70 Months 11 Days 28 If less than one day hr. min.

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

10. Usual occupation House Wife

11. Industry or business _____

12. Name Thomas Hale

13. Birthplace Unknown
(City, town, or county) (State or foreign country)

14. Maiden name Unknown

15. Birthplace Unknown
(City, town, or county) (State or foreign country)

16. (a) Informant Earl Sillyman
(b) Address Ben Davis mo

17. (a) Burial (b) Date thereof 2/11/41
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Emery

18. (a) Signature of funeral director Gayard V. Elliott
(b) Address Houston mo.
19. (a) Feb. 10/1941 (b) Mabel Shacklett
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb day 8
year 1941 hour 9 minute P.M.

21. I hereby certify that I attended the deceased from Feb 1, 1941, to Feb. 8, 1941, that I last saw her alive on Feb. 6, 1941 and that death occurred on the date and hour stated above.

Immediate cause of death Coronary occlusion

Due to Decompensated Hypertensive Cardiac renal

Due to vascular disease

Other conditions Acute Bronchitis
(Include pregnancy within 3 months of death)

Major findings: Of operations 7/8/0
Of autopsy _____

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) All
While at work (e) Means of injury _____

28. Signature H. M. Gillman (M. D. or other) M.D.
Address Houston mo Date signed 2-10-41

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

7
0
0

RECEIVED

District Health Officer No. 5,

District File Number 341376

Date Filed _____

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 Frank E. Hood

Licensed Embalmer No. 4026

P. O. Address Houston, 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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 8429

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. 863

Primary Registration District No. 6137

Registrar's No.

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

1. PLACE OF DEATH:

(a) County Texas
(b) City or town Amey, T.O.
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution..... (Specify whether
In this community..... (Specify whether
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State..... (b) County.....
(c) City or town..... (If outside city or town limits write "RURAL")
(d) Street No..... (If rural, give location)
(e) If foreign born, how long in U. S. A.?..... years.

3. (a) PRINT FULL NAME

Hannah Anna Sillyman

3. (b) If veteran, name war.....

3. (c) Social Security No.....

4. Sex F

5. Color or race W

6. (a) Single, widowed, married, divorced on

6. (b) Name of husband or wife.....

6. (c) Age of husband, or wife, if alive..... years

7. Birth date of deceased Feb 14 1870
(Month) (Day) (Year)

8. AGE: Years 70 Months 11 Days 28
If less than one day hr. min.

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

10. Usual occupation.....

11. Industry or business.....

12. Name.....

13. Birthplace..... (City, town, or county) (State or foreign country)

14. Maiden name.....

15. Birthplace..... (City, town, or county) (State or foreign country)

16. (a) Informant.....

(b) Address.....

17. (a)..... (b) Date thereof..... (Month) (Day) (Year)

(c) Place: burial or cremation.....

18. (a) Signature of funeral director.....

(b) Address.....

19. (a) 2-10-41 (b) Mabel Shacklett
(Date received local registrar) (Registrar's signature)

20. MEDICAL CERTIFICATION

20. DATE OF DEATH Month Feb day 8
year..... hour..... minute..... M.

21. I hereby certify that I attended the deceased from....., 19..... to....., 19.....
that I have seen him alive on....., 19.....
and that death occurred on the date and hour stated above.

Immediate cause of death.....

Due to.....

Due to.....

Other conditions..... (Include pregnancy within 3 months of death)

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.....

(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?

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

23. Signature L. M. Dillman (M. D. or other)

Address Houston Mo. Date signed.....

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

