

FILED OCT 24 1948

Registration District No. **128**

Primary Registration District No. **5466**

Registrar's No. **809**

1. PLACE OF DEATH:

(a) County **GREENE**
 (b) City or town **Rural, S. Campbell Twp**
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
OZARK OSTEOPATHIC HOSPITAL
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution **41 days**
(Specify whether)
 In this community **0**
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo** (b) County **Douglas**
 (c) City or town **Brownbranch Rural**
(If outside city or town limits, write "RURAL")
 (d) Street No. _____
(If rural, give location)
 (e) Citizen of foreign country? **No** (Yes or No)
 If yes, name country _____

3. (a) PRINT FULL NAME **JAMES P. SILER**

3. (b) If veteran, name war **No** 3. (c) Social Security No. **None**

4. Sex **Male** 5. Color or race **white** 6. (a) Single, widowed, married, divorced **widowed**
 6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
 7. Birth date of deceased **Jan 17 1866**
(Month) (Day) (Year)

8. AGE: Years **80** Months **9** Days **22** If less than one day _____ hr. _____ min.

9. Birthplace **Rock Springs Georgia**
(City, town, or county) (State or foreign country)

10. Usual occupation **Farmer**

11. Industry or business _____

MOTHER FATHER
 12. Name **James Siler**
 13. Birthplace **Mo**
(City, town, or county) (State or foreign country)
 14. Maiden name **Elizabeth Hicks**
 15. Birthplace **Mo**
(City, town, or county) (State or foreign country)

16. (a) Informant **Russell Siler**
 (b) Address **Brownbranch, Mo**

17. (a) **Rural** (b) Date thereof **10-8-46**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Bethel Mo**

18. (a) Signature of funeral director **Clabing feed**

(b) Address **Ava, Mo**

19. (a) **10-8-46** (b) **W. S. Hurdley MD**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **10** day **6** year _____ hour **10** minute **15 P.M.**

21. I hereby certify that I attended the deceased from **8-76** 19 **46** to **10-6** 19 **46**
 that I last saw him alive on **10-6** and that death occurred on the date and hour stated above.

Immediate cause of death **uremia** Duration _____

Due to _____

Due to _____

Other conditions **fractured hip (left)**
(Include pregnancy within 3 months of death)

41 days duration

Major findings: Of operations _____

Of autopsy _____

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, **in the absence of REQUESTED**

(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 **Yes**

23. Signature **R. A. Michael MD** (M.D. or other) _____
 Address **Springfield, Mo** Date signed **10-7-46**

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 *W. B. Hutchinson*.....

Licensed Embalmer No. *3431*.....

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

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

X

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. *Nov*

Registration District No. *128*

Primary Registration District No. *5466*

Registrar's No. *809*

1. PLACE OF DEATH: *Shreve*

(a) County.....

(b) City or town..... *Rural*
(If outside city or town limits, write "RURAL" and name of township)

(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 years, months or days) (Specify whether

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) Citizen of foreign country?..... (Yes or No)
If yes, name country.....

3. (a) PRINT FULL NAME *James P. Siler*

3. (b) If veteran, name war..... 3. (c) Social Security No.....

4. Sex *M* 5. Color or race *W* 6. (a) Single, widowed, married, divorced *Wed*

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

7. Birth date of deceased: *Jan 17*
(Month) (Day) (Year)

8. AGE: Years *80* Months *9* Days *18* If less than one day, hr. min.

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

10. Usual occupation.....

11. Industry or business.....

MOTHER FATHER { 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) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)

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

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

19. (a) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month *Nov* year *1946* hour *10* minute *15* M.

21. I hereby certify that I attended the deceased from *10* to *11*, 19.....; that I last saw him *alive* on *11-25-46*, 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.....

Duration.....

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) *ACCIDENT*

(b) Date of occurrence *8-25-46*

(c) Where did injury occur? *DOUGLAS CO*
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? *HOME*

While at work: (Specify type of place) (e) Means of injury *FALL*

23. Signature *R.A. Michael* (Name of other) *?*
Address *Springfield, Mo.* Date signed *11-5-46*

SUPPLEMENTARY

20746

33320