S. No. 2
—1/47
5-17-39

FEDERAL SECURITY AGENCY
National Office of Vital Statistics
FILED JAN 8 1948

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 41424

Registration District No. 128 — Primary Registration District No. 2000 — Registrar's No. 1116

1. PLACE OF DEATH:

(a) County: Greene
(b) City or town: Springfield (If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 1719 W. Division (If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution ..... (Specify whether In this community 3 years years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State: Mo. (b) County: Greene 39
(c) City or town: Springfield 2 (If outside city or town limits, write "RURAL")
(d) Street No.: 1719 West Division 6 (If rural, give location)
(e) Citizen of foreign country? No. (Yes or No) 0
If yes, name country .....

3. (a) PRINT FULL NAME: Grace Margeret Silvers.
3. (b) If veteran, name war: None
3. (c) Social Security No.: 493-12-0032
4. Sex: Female
5. Color or race: White
6. (a) Single, widowed, married, divorced: Married
6. (b) Name of husband or wife: Jesse Earl Silvers
6. (c) Age of husband or wife if alive: 59 years
7. Birth date of deceased: February 5, 1892 (Month) (Day) (Year)

8. AGE: Years 55 | Months 10 | Days 19 | If less than one day ..... hr. ..... min.

9. Birthplace: St. Joseph (City, town, or county) Mo. (State or foreign country) 6
10. Usual occupation: House Wife
11. Industry or business: ~~Mo.~~ At Home

FATHER
12. Name: J. Augustine
13. Birthplace: (City, town, or county) Unknown (State or foreign country) 7

MOTHER
14. Maiden name: Viola Myrick
15. Birthplace: Union Grove Mo. (City, town, or county) (State or foreign country) 0

16. (a) Informant: Jesse E. Silvers
(b) Address: Springfield Mo.
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: 12-27-1947 (Month) (Day) (Year)
(c) Place: burial or cremation: Green Lawn Cem.
18. (a) Signature of funeral director: J W Klingner & Co.
(b) Address: Springfield Mo.
19. (a) 12-27-47 (Date received local registrar) (b) W E Handley MD (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month December day 24, year 1947 hour 3 minute 15 P. M.

21. I hereby certify that I attended the deceased from 27 March 1946, to 24 December 1947 that I last saw her alive on 29 September 1947 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Cardiac failure	
Due to: Myocardial insufficiency	Nov. 45
Due to: Arterial hypertension	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations	
Of autopsy	

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PHYSICIAN — Underline the cause of 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 0

23. Signature: J. M. Klingner (M. D. or other) M.D.
Address: Springfield, Mo. Date signed: 26 Dec. 47

Jefferson City Printing Co. (Licensed Embalmer's Statement on Reverse Side)

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

G. M. Klingner

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.....

Licensed Embalmer No. 4071

P. O. Address Springfield

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.