

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

Dr. Silsby
State File No. 905

FILED JAN 16 1949

BIRTH NO. _____		REG. DIST. NO. <u>128</u>		PRIMARY REG. DIST. NO. <u>2000</u>		Registrar's No. <u>24</u>	
1. PLACE OF DEATH a. COUNTY <u>Greene</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Greene</u>			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Springfield</u>		c. LENGTH OF STAY (In this place) <u>8 yrs.</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Springfield</u>		27 2 6 0	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>St. John Hosp.</u>				d. STREET ADDRESS (If rural, give location) <u>529 E. Delmar</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>Capitola</u> b. (Middle) _____ c. (Last) <u>Else</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>Jan 10 1949</u>				
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED <u>Widowed</u>	8. DATE OF BIRTH <u>Oct. 13 1867</u>	9. AGE (In years last birthday) <u>81</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Home</u>		10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (State or foreign country) <u>Tennessee</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13a. FATHER'S NAME <u>Joseph E. Halbert</u>		13b. MOTHER'S MAIDEN NAME <u>Martha Beard</u>		14. NAME OF HUSBAND OR WIFE <u>Fred A. Else</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NO</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Mrs. L.C. Hankins Springfield</u>			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Arteriosclerosis & Cerebral hemorrhage</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. <u>Arteriosclerosis</u> DUE TO (b) _____ DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Coronary disease</u>				INTERVAL BETWEEN ONSET AND DEATH 20 yrs <u>36 hours</u> <u>20 yrs</u>	
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION <u>450''</u>				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT SUICIDE (Specify) _____		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____		21c. CITY, TOWN, OR TOWNSHIP (COUNTY) (STATE) <u>Springfield Greene, Mo.</u>			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? _____			
22. I hereby certify that I attended the deceased from <u>June 1948</u> to <u>Jan 10 1949</u> , that I last saw the deceased alive on <u>Jan 9, 1949</u> , and that death occurred at <u>8:15 a.m.</u> from the causes and on the date stated above. ✓							
23a. SIGNATURE (Degree or title) <u>H.H. Lohmeyer M.D.</u>				23b. ADDRESS <u>609 Cherry St.</u>		23c. DATE SIGNED <u>Jan 10 '49</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>1/12/49</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Mt. Home, Ark</u>		24d. LOCATION (City, town, or county) (State) <u>Mt. Home, Ark.</u>		
DATE REC'D BY LOCAL REG. <u>1-11-49</u>		REGISTRAR'S SIGNATURE <u>W.S. Handley M.D.</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>H.H. Lohmeyer Springfield, Mo</u>			

(Licensed Embalmer's Statement on Reverse Side)

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

JAN 22 1949

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 _____

Student Embalmer No. _____

working under my personal supervision.

Signed _____

Walter E. Hamble

Signed _____
Student Embalmer

Licensed Embalmer No. *3208*

P. O. Address *Springfield 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, fact should be so stated above.