

FILED FEB 6 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

Dr. Don Silsby
State File No. 826

0396

BIRTH NO.		REG. DIST. NO. 128	PRIMARY REG. DIST. NO. 2000	Registrar's No. 99	
1. PLACE OF DEATH a. COUNTY Greene		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Greene			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Springfield		c. LENGTH OF STAY (If in institution) 55 yrs			
d. FULL NAME OF HOSPITAL OR INSTITUTION 838 West Walnut		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Springfield			
3. NAME OF DECEASED (Type or Print) a. (First) Mac Travis		b. (Middle) D.		c. (Last) McCoy	
5. SEX Male		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	
8. DATE OF BIRTH Jan, 7, 1861		9. AGE (In years, last birthday) 89			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Meat Business		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Fairfield, Illinois	
12. CITIZEN OF WHAT COUNTRY? U. S. A.		13a. FATHER'S NAME John McCoy			
13b. MOTHER'S MAIDEN NAME Unknown		14. NAME OF HUSBAND OR WIFE Mrs Lena McCoy			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT'S SIGNATURE OR NAME Mrs Lena McCoy Spfld, Mo.	
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) Myocarditis ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Senility. Age 89+ DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			INTERVAL BETWEEN ONSET AND DEATH 2 wks
19a. DATE OF OPERATION none		19b. MAJOR FINDINGS OF OPERATION none		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.		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 Jan 15, 1946, to Feb 1, 1950, that I last saw the deceased alive on Jan 31, 1950, and that death occurred at 12:20 A.M., from the causes and on the date stated above.					
23a. SIGNATURE Don H. Silsby (Degree or title) M.D.		23b. ADDRESS Springfield Mo		23c. DATE SIGNED 2/2/50	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 2/2/50		24c. NAME OF CEMETERY OR CREMATORY Maple Park	
24d. LOCATION (City, town, or county) Springfield, Mo.		24e. LOCATION (City, town, or county) (State)			
DATE REC'D BY LOCAL REG. 2-2-50		REGISTRAR'S SIGNATURE W.E. Handley M.D.		25. FUNERAL DIRECTOR'S SIGNATURE H. H. Lohmeyer ADDRESS Springfield, Mo	

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

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.....

Signed.....

Student Embalmer

Licensed Embalmer No. *4734*

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.