

FILED APR 10 1950

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **8331**  
**306**  
Registrar's No. \_\_\_\_\_

0396

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

BIRTH NO. _____		REG. DIST. NO. <b>128</b>		PRIMARY REG. DIST. NO. <b>2000</b>		Registrar's No. _____	
1. PLACE OF DEATH a. COUNTY <b>Greene</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Greene</b>			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>Springfield</b>		c. LENGTH OF STAY (in this place) <b>65 years</b>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>Springfield</b>		<b>0396</b> <b>D</b>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>940 West Harrison</b>				d. STREET ADDRESS (If rural, give location) <b>940 West Harrison</b>			
3. NAME OF DECEASED (Type or Print) <b>William</b>		a. (First) <b>William</b>		b. (Middle) <b>R.</b>		c. (Last) <b>Rollston</b>	
4. DATE OF DEATH <b>March 30 1950</b>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>		8. DATE OF BIRTH <b>Jan. 27, 1877</b>		9. AGE (In years last birthday) <b>73</b>	
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Operator Grocery Store</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Grocery</b>	
11. BIRTHPLACE (State or foreign country) <b>Kentucky</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13a. FATHER'S NAME <b>Henry Rollston</b>		13b. MOTHER'S MAIDEN NAME <b>Molley Robertson</b>	
14. NAME OF HUSBAND OR WIFE <b>Mabel Rollston</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>		17. INFORMANT'S SIGNATURE OR NAME <b>Mrs Mabel Rollston, Springfield, Mo.</b>	
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, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Coronary thrombosis,</b> <b>Myocarditis, Chronic</b> ANTECEDENT CAUSES <b>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.</b> DUE TO (b) _____ DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS <i>Conditions contributing to the death but not related to the disease or condition causing death.</i>				INTERVAL BETWEEN ONSET AND DEATH <b>20 minutes</b> <b>1-2 yrs.</b> <b>4201</b>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input 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 _____, 19 <b>48</b> , to <b>Mar 30, 1950</b> , that I last saw the deceased alive on _____, 19 <b>48</b> , and that death occurred at <b>6:35 A</b> m., from the causes and on the date stated above.							
23a. SIGNATURE <b>Don J. Silsby MD</b> (Degree or title)				23b. ADDRESS <b>Springfield, Mo</b>		23c. DATE SIGNED <b>3-31-50</b>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24b. DATE <b>April 2, 1950</b>		24c. NAME OF CEMETERY OR CREMATORY <b>Maple Park</b>		24d. LOCATION (City, town, or county) (State) <b>Springfield, Mo.</b>	
DATE REC'D BY LOCAL REG. <b>4-5-50</b>		REGISTRAR'S SIGNATURE <b>W.T. Handley III</b>		25. FUNERAL DIRECTOR'S SIGNATURE <b>Alma Sabaney, Springfield, Mo.</b>		ADDRESS <b>B. 7. W</b>	

APR 22 1950

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.

Student .....  
Student Embalmer

Signed *Lee Mason* .....

Licensed Embalmer No. *4568*

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.