

FILED AUG 17 1955

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

27003

State File No. _____

BIRTH NO. _____		REG. DIST. NO. <u>209</u>		PRIMARY REG. DIST. NO. <u>3043</u>		Registrar's No. <u>235</u>	
1. PLACE OF DEATH a. COUNTY <u>Marion</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Marion</u>			
b. CITY OR TOWN <u>Hannibal</u>		c. LENGTH OF STAY (in this place) _____		c. CITY OR TOWN <u>Hannibal</u>		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>St. Elizabeth Hospital</u>				e. STREET ADDRESS (If rural, give location) <u>921 Lindell Avenue 064 1/2</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>George</u> b. (Middle) <u>W.</u> c. (Last) <u>Silman</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>Aug 8 1955</u>				
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>2/22/1892</u>		9. AGE (In years last birthday) <u>63</u>	UNDER 1 YEAR Months _____ Days _____	IF UNDER 1 HR. Hours _____ Mins. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Operated Cafe (Retired)</u>			10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (City and State or Foreign Country) <u>Marion County, Mo.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13a. FATHER'S NAME <u>James Silman</u>		13b. MOTHER'S MAIDEN NAME <u>Mary Elder</u>		14. NAME OF HUSBAND OR WIFE <u>Ester Pearl Silman</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. _____		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Mrs. Ester Pearl Silman 921 Lindell</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 <u>Hannibal, Mo.</u> I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Profuse Hemorrhage</u> ANTECEDENT CAUSES <u>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.</u> DUE TO (b) <u>Ruptured Spleen and Varices</u> DUE TO (c) <u>Chirolois (Toxic) LIVER</u> II. OTHER SIGNIFICANT CONDITIONS <u>Conditions contributing to the death but not related to the disease or condition causing death.</u> <u>5810</u>					INTERVAL BETWEEN ONSET AND DEATH <u>1 Day</u> <u>3 Days</u> <u>?</u>
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____				20. AUTOPSY? YES <input checked="" 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) (Min.) _____		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>11:30 P.M. 8/5/55</u> , to <u>Jan 18, 1955</u> , that I last saw the deceased alive on <u>9/8/55</u> , 19 <u>55</u> and that death occurred at <u>9:10 p.m.</u> , from the causes and on the date stated above.							
23a. SIGNATURE (Name or title) <u>J. E. Sultman M.D.</u>				23b. ADDRESS <u>Hannibal Mo</u>		23c. DATE SIGNED <u>9/10/55</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>8/11/1955</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Grand View Burial Pk.</u>		24d. LOCATION (City, town, or county) (State) <u>Hannibal, Mo.</u>		
DATE REC'D BY LOCAL REG. <u>8/12/55</u>		REGISTRAR'S SIGNATURE <u>W. E. M. Lucke By H. C. Fisher</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Michael & O'Sullivan</u>		ADDRESS <u>Hannibal, Mo.</u>	

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

RECEIVED AUG 16 1955
MARION CO. HEALTH DEPT.
DATE FILED AUG 16 1955

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.....
Signature of Student Embalmer

Signed *Michael J. O'Rourke*

Licensed Embalmer No. *324*
P. O. Address *Hannibal*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.