

Dr. Silsby Sr.
FILED APR 23 1956

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

12978
STATE FILE NUMBER

Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 370

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, give TOWNSHIP only) OR TOWN Springfield		c. CITY OR TOWN Springfield <u>0.346</u>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Burge Hospital		d. STREET ADDRESS 1254 E/ Bennett	
3. NAME OF DECEASED (Type or print) Ollie Scroggs		4. DATE OF DEATH April 17 1956	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 2 1894
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HARDWARE DEPT.		11. BIRTHPLACE (City and state or country) SPRINGFIELD, MO.	
13. FATHER'S NAME UNKNOWN		14. MOTHER'S MAIDEN NAME UNKNOWN	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) YES W.W. # 1		16. SOCIAL SECURITY NO. 491-05-0124	
17. INFORMANT Mary Scroggs		Address Springfield, Mo.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonitis, migratory			INTERVAL BETWEEN ONSET AND DEATH 6 mo.
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) _____ DUE TO (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Bronchiectasis, left basilar region			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour _____ Month, Day, Year _____ a. m. _____ p. m. _____			
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	
		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from Oct. 1, 1955 to April 16, 56 and last saw her <u>living</u> on 4/16/56 Death occurred at 1:15 P.M. m on the date stated above DON H. SILSBY M.D. from the causes stated.			
22a. SIGNATURE Wm H. Silsby M.D. (Degree or title)		22b. ADDRESS 326 Landers Bldg. SPRINGFIELD, MO.	
		22c. DATE SIGNED 4/19/1956	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 4/16/56	
23c. NAME OF CEMETERY OR CREMATORY St. Mary's		23d. LOCATION (City, town, of county) (State) Springfield, Mo.	
24. FUNERAL DIRECTOR H.H. Lohmeyer ADDRESS Springfield, Mo.		25. DATE RECD. BY LOCAL REG. 4-20-56	
26. REGISTRAR'S SIGNATURE Edna Williams			

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

APR 25 1956

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was
by me, or by, Student Embalmer No.
working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed *Lynn T. Swedley*.....

Licensed Embalmer No. *4*

P. O. Address *Spring*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING.
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.