

Dr. H. Silsby

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-017864

STATE FILE NUMBER

FILED JUN 2 1958

Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 539

S. 300
1-57

All diseases in Part I must be causally related. No symptoms will be listed.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN SPRINGFIELD 039A
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION ST. JOHN'S HOSP.		Length of stay in 1b 36 YRS.	d. STREET ADDRESS (If outside, give location) 1026 MONROE TR.
3. NAME OF DECEASED (Type or print) First Middle Last KATHERINE McCRARY			4. DATE OF DEATH Month Day Year MAY 24 1958
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> 2 DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JAN. 26 1872
9. AGE (In years last birthday) 86		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOME	11. BIRTHPLACE (City and state or country) KEOKUK, IOWA
12. CITIZEN OF WHAT COUNTRY? USA		13a. FATHER'S NAME THOMAS W. UTLEY	13b. MOTHER'S MAIDEN NAME HANNAH GRAHAM
14. NAME OF HUSBAND OR WIFE GEO. F. McCRARY (DEC.)		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO	16. SOCIAL SECURITY NO. NO
17. INFORMANT H.H. LOHMEYER		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) <u>Congenital Heart failure</u> DUE TO (b) <u>Arteriosclerotic Cardiovascular unknown disease</u> DUE TO (c) <u>4221</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Tumor left breast</u>			INTERVAL BETWEEN ONSET AND DEATH <u>3 months</u>
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 <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 <u>Springfield Greene MO</u>	
21. Attended the deceased from <u>Dec 8 '52</u> to <u>May 24 '58</u> and last saw her alive on <u>May 23 '58</u> Death occurred at <u>7:42 A.M.</u> m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>H. Silsby M.D.</u>		22b. ADDRESS <u>609 Cherry St.</u>	
22c. DATE SIGNED <u>May 26 58</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE 5/27/58	23c. NAME OF CEMETERY OR CREMATORY EASTLAWN	23d. LOCATION (City, town, or county) (Specify) SPRINGFIELD, MO.
24. FUNERAL DIRECTOR H.H. LOHMEYER		ADDRESS SPRINGFIELD, MO.	25. DATE RECD. BY LOCAL REG. 5-28-58
		26. REGISTRAR'S SIGNATURE <u>Effie G. Melton</u>	

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 *A. J. Mc Cann*

Licensed Embalmer No. *3727*
P. O. Address *Springfield, Ill.*

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.