

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-036068  
STATE FILE NUMBER

Don H. Silsby, M.D.  
FILED NOV 10 1958  
Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 1046

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, give TOWNSHIP only) OR TOWN <b>Springfield</b>		c. CITY OR TOWN <b>Springfield</b>	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>2500 N. Robberson</b>		Length of stay in lb <b>11 years</b>	
d. STREET ADDRESS <b>2500 N. Robberson</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <b>Mark</b> Middle <b>F.</b> Last <b>Lillard</b>			4. DATE OF DEATH Month <b>October</b> Day <b>30</b> Year <b>1958</b>		
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5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> / DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>January 18, 1875</b>	9. AGE (In years last birthday) <b>83</b>	IF UNDER 1 YEAR Months <b>9</b> Days <b>12</b>	IF UNDER 24 HRS. Hours <b></b> Min. <b></b>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Farmer</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>On Farm</b>	11. BIRTHPLACE (City and state or country) <b>Greene County, Missouri</b>	12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
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13a. FATHER'S NAME <b>John H. Lillard</b>	13b. MOTHER'S MAIDEN NAME <b>Margaret E. Lillard</b>	14. NAME OF HUSBAND OR WIFE <b>Anna Lillard</b>
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>None</b>	16. SOCIAL SECURITY NO. <b>unknown</b>	17. INFORMANT <b>Mrs. Anna Lillard</b>	Address <b>Springfield, Mo.</b>
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral hemorrhage</b>		INTERVAL BETWEEN ONSET AND DEATH <b>7 days</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) _____	331X
	DUE TO (c) _____	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		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.)
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20c. TIME OF INJURY Hour _____ 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 <b>Springfield</b>	COUNTY <b>Mo</b>	STATE <b>Mo</b>
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21. I attended the deceased from <b>Oct 21, '58</b> to <b>Oct 30 '58</b> and last saw him alive on <b>Oct 28 '58</b> Death occurred at <b>6 A.</b> m on the date stated above; and to the best of my knowledge, from the causes stated.
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22a. SIGNATURE <b>Don H. Silsby M.D.</b>	(Degree or title)	22b. ADDRESS <b>Springfield Mo</b>	22c. DATE SIGNED <b>10-31-58</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>Nov. 1, 1958</b>	23c. NAME OF CEMETERY OR CREMATORY <b>White Chapel</b>	23d. LOCATION (City, town, or county) (State) <b>Springfield, Missouri</b>
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24. FUNERAL DIRECTOR <b>Parmer-Schmidt Funeral Home</b> <b>Springfield, Mo</b>	ADDRESS <b>Home 4-3-58</b>	25. DATE RECD. BY LOCAL REG. <b>10-31-58</b>	26. REGISTRAR'S SIGNATURE <b>Effie E. Melton</b>
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(Licensed Embalmer's Statement on Reverse Side)

S. 300  
1-57

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

*Pilobry*

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 *L. Pauline Gorman*

Licensed Embalmer No. *3177*  
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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.