

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-61-030106

STATE FILE NUMBER

Registration District No. 209 Primary Registration District No. 3043 Registrar's No. 291

AMENDED

FILED SEP 6 1961

1. PLACE OF DEATH a. COUNTY Marion		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY Ralls	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Hannibal		Length of stay in 1b 2 wks.	c. CITY OR TOWN New London Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Becky Thatcher Home		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First James Middle William Last Silbey			4. DATE OF DEATH Month Aug. Day 15 Year 1961		
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 5/31/1882	9. AGE (last birthday) 79	IF UNDER 1 YEAR Months Days Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer	10b. KIND OF BUSINESS OR INDUSTRY Laddonia, Missouri	11. BIRTHPLACE (City and state or country) USA	12. CITIZEN OF WHAT COUNTRY USA
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13a. FATHER'S NAME Samuel Silvey	13b. MOTHER'S MAIDEN NAME Matilda Walkley	14. NAME OF HUSBAND OR WIFE Cora Silbey
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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) no	17. INFORMANT Address Lonnie Silvey, New London, Mo.
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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) Acute myocardial infarctinn		INTERVAL BETWEEN ONSET AND DEATH 4 days
DUE TO (b) Arteriosclerotic vascular disease severe		?
DUE TO (c)		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Cerebral vascular hemorrhage, old	PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
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19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input 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 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
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21. I attended the deceased from 9/10/61 to 9/12/61 and last saw ^{her}him alive on 8/22/61
Death occurred at _____ on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) Robert J. Lanning - MD	22b. ADDRESS 115 N. 5th St., Hannibal, Mo.	22c. DATE SIGNED
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23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE Aug. 17-1961	23c. NAME OF CEMETERY OR CREMATORY Fairview Cemetery	23d. LOCATION (City, town, or county) (State) Grassy Creek Missouri
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24. FUNERAL DIRECTOR ADDRESS Megown Fun. Home, Frankford, Missouri	25. DATE RECD. BY LOCAL REG. 9-6-61	26. REGISTRAR'S SIGNATURE Harold W. Miller M.D.
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(Licensed Embalmer's Statement on Reverse Side)

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

ITEM NO. SHOULD READ

BY AFFIDAVIT OF

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 _____

Licensed Embalmer No. _____

P. O. Address _____

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.