

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

No. 2
41

FILED SEP 23 1941

Registration District No. 17

Primary Registration District No. 4011

Registrar's No.

1. PLACE OF DEATH:

(a) County Atchison
(b) City or town Fairfax
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether
In this community Twenty Nine Years (Specify whether
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Atchison
(c) City or town Fairfax
(If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 22nd
year 1941 hour 3 minute _____ A. M.
21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;

that I last saw _____ alive on _____, 19____;
and that death occurred on the date and hour stated above.
Immediate cause of death _____ Duration
Head and face injuries In
caused by overturning of start
Due to truck.

Due to _____
Other conditions _____
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____
Of autopsy _____
PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) Accident
(b) Date of occurrence Aug. 22nd 1941
(c) Where did injury occur? Fairfax Atchison Mo
(City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?
North edge of Fairfax on
Rightway (Specify type of place)
(e) Means of injury Head Cru
Driving truck shed
3. Signature Walter B. Black (M. D. or other) Cor
Address Westboro. Missouri Date signed Aug. 22. 41

3. (a) PRINT FULL NAME James Smith Sillers

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased Dec. 5th. 1912
(Month) (Day) (Year)

8. AGE: Years 28 Months 8 Days 17 If less than one day hr. _____ min. _____

9. Birthplace Near Fairfax, Mo.
(City, town, or county) (State or foreign country)

10. Usual occupation Farming

11. Industry or business _____

12. Name Jas. S. Sillers (Sr)

13. Birthplace Near Fairfax, Mo.
(City, town, or county) (State or foreign country)

14. Maiden name Mona Smith

15. Birthplace Near Rock Port, Mo.
(City, town, or county) (State or foreign country)

16. (a) Informant Jas. S. Sillers (Sr)

(b) Address Fairfax, Missouri

17. (a) Burial (b) Date thereof Aug 24-1941
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial Pleasant Middle Cemetery

(a) Signature of funeral director H. H. Schofield Sons

(b) Address Fairfax, Mo
19. (a) Aug 24, 41 (b) Walter B. Black
(Date received local registrar) (Registrar's signature)

15, (Licensed Embalmer's Statement on Reverse Side) Aug. 22. 41

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.....
....., Registered Apprentice No.....
working under my personal supervision.

Signed Marvin N. Scholes

Licensed Embalmer No. 4167

P. O. Address Fairfax, 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 this body is not embalmed, fact should be so stated above.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 27674

Registration District No. 17

Primary Registration District No. 4011

Registrar's No. _____

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(a) County Atchison
(b) City or town Fairfax
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: _____
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether
In this community _____
years, months or days)

3. (a) PRINT FULL NAME James S. Siller

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex m 5. Color or race W 6. (a) Single, widowed, married, divorced _____

6. (b) Name of husband or wife Worthy Thursday 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased _____ (Month) _____ (Day) _____ (Year)

8. AGE: Years _____ Months _____ Days _____ If less than one day _____ min.

9. Birthplace _____ (City, town, or county) _____ (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

12. Name _____

13. Birthplace _____ (City, town, or county) _____ (State or foreign country)

14. Maiden name _____

15. Birthplace _____ (City, town, or county) _____ (State or foreign country)

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof _____ (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) 8-22-41 (b) Getta B. Black
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____
(c) City or town _____ (If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug Day 22 Year 1941 Hour _____ Minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____; that I last saw him/her alive on _____, 19____; and that death occurred on the date and hour stated above. (Immediate cause of death) _____

Duration _____

Due to _____

Due to _____

Other conditions _____ (Include pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy _____

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

(c) Where did injury occur? _____ (City or town) _____ (County) _____ (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place) _____ (e) Means of injury _____

23. Signature _____ (M. D. or other) _____

Address _____ Date signed _____

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SUPPLEMENTARY

MOTHER FATHER

