

JUN 28 1942  
 JUN 23 1942

Registration District No. \_\_\_\_\_

Primary Registration District No. 1001

1. PLACE OF DEATH  
 (a) County Jackson  
 (b) City or town Kansas City Mo  
 (If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution: Northwest Hospital  
 (If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution 3 days  
 (Specify whether years, months or days) 3 Days

2. USUAL RESIDENCE OF DECEASED:  
 (a) State Missouri (b) County Rae  
 (c) City or town Rural  
 (If outside city or town limits, write "RURAL")  
 (d) Street No. \_\_\_\_\_ (If rural, give location) \_\_\_\_\_  
 (e) Citizen of foreign country? NO (Yes or No)  
 If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME ELIZABETH SILLIX  
 3. (b) If veteran, name war no  
 3. (c) Social Security No. no

MEDICAL CERTIFICATION  
 20. DATE OF DEATH: Month 5 day 23  
 year 1942 hour 10 minute 54 P.M.  
 21. I hereby certify that I attended the deceased from May 21 1942 to May 23 1942  
 that I last saw him alive on May 23 1942  
 and that death occurred on the date and hour stated above.

4. Sex Female 5. Color or race white  
 6. (a) Single, widowed, married, divorced married  
 6. (b) Name of husband or wife Robert Sillix  
 6. (c) Age of husband or wife if alive 72 years  
 7. Birth date of deceased: (Month) 3 (Day) 7 (Year) 1872

Immediate cause of death: Diabetic coma  
 Due to: Cancer of the pancreas with metastasis to liver  
 Due to: Diabetic  
 Other conditions: \_\_\_\_\_  
 (Include pregnancy within 3 months of death)

8. AGE: Years 70 Months 2 Days 17 1/2 hr. \_\_\_\_\_ min. \_\_\_\_\_  
 9. Birthplace: \_\_\_\_\_ (City, town, or county) \_\_\_\_\_ (State or foreign country) \_\_\_\_\_

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

10. Usual occupation Housewife  
 11. Industry or business \_\_\_\_\_  
 12. Name Jake Frazier  
 13. Birthplace South Carolina  
 (City, town, or county) \_\_\_\_\_ (State or foreign country) \_\_\_\_\_  
 14. Maiden name Unknown  
 15. Birthplace South Carolina  
 (City, town, or county) \_\_\_\_\_ (State or foreign country) \_\_\_\_\_  
 16. (a) Informant Robert Sillix  
 (b) Address Orick Mo  
 17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: 5-25-42  
 (Month) (Day) (Year)  
 (c) Place: burial or cremation South Dixie Council Raylo  
 18. (a) Signature of funeral director C. V. Gibson  
 (b) Address Orick Mo  
 19. (a) 5-24-42 (Date received local registrar) (b) M. M. Brown (Registrar's signature)

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 fall  
 23. Signature F. W. Thompson (M. D. or other) \_\_\_\_\_  
 Address 1020 Chambers Date signed 5/24/42

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

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1942

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**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.....

Licensed Embalmer No. 2299.....

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 this body is not embalmed, fact should be so stated above.**

# MISSOURI STATE BOARD OF HEALTH STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

State File No. ....

Registration District No. .... Primary Registration District No. .... Registrar's No. 2013

### 1. PLACE OF DEATH:

(a) County.....  
(b) City or town.....  
(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.....  
In this community..... (Specify whether  
years, months or days)

3. (a) PRINT FULL NAME Elizabeth Silley

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

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

6. (b) Name of husband or wife..... 6. (c) Age of husband, or wife, if alive..... year.....

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

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

9. Birthplace Ray Co Mo  
(City, town, or county) 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)

(Burial, cremation, or removal)  
(c) Place: burial or cremation Southwest Cemetery  
South

18. (a) Signature of funeral director South

(b) Address.....

19. (a) 6/10/42 (b) M. M. Brown  
(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) If foreign born, how long in U. S. A.?..... years.

### MEDICAL CERTIFICATION

20. DATE OF DEATH..... month..... day.....  
year..... hour..... minute..... M.

21. I hereby certify that I attended the deceased from....., 19....., to....., 19.....  
that I last saw him..... alive on....., 19.....  
and that death occurred on the date and hour stated above.  
Immediate cause of death.....

Due to.....

Due to.....

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

Major findings:  
Of operations.....

Of autopsy.....

Duration

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.....

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

SUPPLEMENTARY

1942

S-17172