

FILED OCT 20 1943

Registration District No. 2

Primary Registration District No. 4010

1. PLACE OF DEATH:

(a) County Andrew

(b) City or town Rea
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: 1
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution.....
(Specify whether years, months or days)

In this community 23 yrs
(Specify whether years, months or days)

3. (a) PRINT FULL NAME James William Silvers

3. (b) If veteran, name war no

3. (c) Social Security No. no

4. Sex m

5. Color or race W

6. (a) Single, widowed, married, divorced W 2

6. (b) Name of husband or wife.....

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

7. Birth date of deceased July 1 - 1870
(Month) (Day) (Year)

8. AGE: Years 73 Months 2 Days 27
If less than one day hr. min.

9. Birthplace Andrew co mo
(City, town, or county) (State or foreign country)

10. Usual occupation Druggist

11. Industry or business.....

12. Name James R. Silvers

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

14. Maiden name Elysa Schfer

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

16. (a) Informant Mrs. Nona Cole

(b) Address Rea, mo

17. (a) Burial
(Burial, cremation, or removal)

(b) Date thereof 10-1-1943
(Month) (Day) (Year)

(c) Place: burial or cremation Savannah

18. (a) Signature of funeral director E. C. Brest

(b) Address Savannah mo

19. (a) 10-1-43
(Date received local registrar)

(b) F. H. Fitchner
(Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Andrew

(c) City or town Rea
(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.....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 9 day 28
year 1943 hour 4 minute 30 P.M.

21. I hereby certify that attended the deceased from 19 to 19
that I last saw h..... alive on Sept 28 19 43
and that death occurred on the date and hour stated above.

Immediate cause of death Chronic Endocarditis!

Duration ?

Due to.....

Due to.....

Other conditions 92d
(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?
(Specify type of place)

While at work..... (e) Means of injury.....

23. Signature Chaffard R. Steadley
Address Savannah mo Date signed 10/1/43

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

MOTHER FATHER

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 E. C. Breit

Licensed Embalmer No. 2650

P. O. Address Savannah

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.