. S. No. 2
DM—8-43
v. 5-17-39
I X37823

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED OCT 3 1946

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

29538

State File No.

Registration District No. 37 Primary Registration District No. 4049 Registrar's No. 16

1. PLACE OF DEATH:

(a) County Boone

(b) City or town Centralia Mo (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) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Boone

(c) City or town Centralia (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

3. (a) PRINT FULL NAME Kate Geneva Silner

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex F

5. Color or race W

6. (a) ~~Single~~, widowed, ~~married~~, ~~divorced~~ Widow

6. (b) Name of husband ~~or wife~~ William Jessie Silner

(c) Age of husband or wife if alive years

7. Birth date of deceased Aug (Month) 23 (Day) 1881 (Year)

8. AGE: Years 65 Months 0 Days 13 If less than one day hr. min.

9. Birthplace ~~Kentucky~~ Middle Grove Mo (City, town, or county) (State or foreign country)

10. Usual occupation Housekeeper

11. Industry or business

FATHER
12. Name Robert Smith
13. Birthplace Kentucky (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Sarah Seymour
15. Birthplace D.K. (City, town, or county) (State or foreign country)

16. (a) Informant Leroy Silner
(b) Address Centralia Mo

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 8-1946 (Month) (Day) (Year)
(c) Place: burial or cremation Centralia Mo

18. (a) Signature of funeral director Gene Jennings
(b) Address Centralia Mo

19. (a) Oct 1-1946 (Date received local registrar) (b) Maud McBride (Registrar's signature)

MEDICAL CERTIFICATION

20. **DATE OF DEATH:** Month Sept day 6 year 1946 hour 2 minute 30 A.M.

21. I hereby certify that I attended the deceased from 12-8-44, 19, to 9-6-46, 19; that I last saw her alive on 2-24-45, 19; and that death occurred on the date and hour stated above.

Immediate cause of death Myocardial Degeneration

Due to Aortic & Mitral Regurgitation

Due to Cardio-Rural Syndrome

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.

31 A

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 P. O. Baker D.D. (M. D. or other)

Address Centralia Mo Date signed 9-17-46

30

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 9,
District File Number
Date Filed 10-3-46

OCT 16 1946

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 Glenn Jennings

Licensed Embalmer No. 4270-

P. O. Address Centralia, 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.