

No. 2  
1-8-43  
5-17-39  
K37823

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

Dr. Don Silsby Jr.  
State File No. 30045  
Registrar's No. 724

FILED SEP 23 1946  
Registration District No. 128

Primary Registration District No. 2000

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

1. PLACE OF DEATH:  
(a) County Greene  
(b) City or town Springfield  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: Burge Hospital  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution Six Days  
(Specify whether  
In this community 36 Years  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:  
(a) State Missouri (b) County Greene  
(c) City or town Springfield  
(If outside city or town limits, write "RURAL")  
(d) Street No. 423 West Talmadge  
(If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Ira Newton Wilson  
(b) If veteran, name war None  
(c) Social Security No. UNK.

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month Sept. day 1st  
year 1946 hour 5 minute 50 P.M.

4. Sex Male 5. Color or race White  
6. (a) Single, widowed, married, divorced Married  
(b) Name of husband or wife Mrs Nora Wilson  
(c) Age of husband or wife if alive 67 years  
7. Birth date of deceased Feb. 18, 1875  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from March 11, 1946 to Sept 1, 1946  
that I last saw him alive on Sept 1, 1946  
and that death occurred on the date and hour stated above.

8. AGE: Years 71 Months 6 Days 13  
If less than one day hr. min.

Immediate cause of death Cardiac failure Duration 1 week  
Due to Bronchiectasis Chronic 7 yrs  
Asthma, bronchial 7 yrs  
Due to Silicosis 25 yrs

9. Birthplace Wayne, County Illinois  
(City, town, or county) (State or foreign country)

10. Usual occupation Manufacturer of Rug Needles

Other conditions (Include pregnancy within 3 months of death)  
Major findings:  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_

MOTHER FATHER  
11. Industry or business \_\_\_\_\_  
12. Name Newton Wilson  
13. Birthplace UNK. Kentucky  
(City, town, or county) (State or foreign country)  
14. Maiden name Melissa Haines  
15. Birthplace Murphreesboro Tenn.  
(City, town, or county) (State or foreign country)

PHYSICIAN  
Underline the cause to which death should be charged statistically.  
106B

16. (a) Informant Howard Wilson (Son)  
(b) Address 710 Mt. Vernon, Springfield, Mo  
17. (a) Burial (b) Date thereof 9/5/46  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation Greenlawn

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? \_\_\_\_\_

18. (c) Signature of funeral director Herman H. Lohmeyer  
(b) Address Springfield, Missouri  
19. (a) 9-4-46 (b) W. H. Harts  
(Date received local registrar) (Registrar's signature)

23. Signature Don Silsby (M. D. or other) M.D.  
Address Springfield, Mo Date signed 9-4-46

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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. *2457*

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.**

X