

**THE DIVISION OF HEALTH  
STANDARD CERTIFICATE OF DEATH**

State File No. **25880**

**FILED AUG 6 - 1953**

BIRTH NO. _____		REG. DIST. NO. <b>276</b>		PRIMARY REG. DIST. NO. <b>5945</b> Registrar's No. <b>44</b>	
1. PLACE OF DEATH a. COUNTY <b>Phelps</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <b>Mo</b> b. COUNTY <b>Phelps</b>		
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>St James Mo</b>		c. LENGTH OF STAY (in this place) <b>6 mo</b>	c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>Rural N. Phelps</b>		d. STREET ADDRESS (If rural, give location) <b>0810</b>
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>Gravelle Nursing Home</b>			d. STREET ADDRESS (If rural, give location) <b>0810</b>		
3. NAME OF DECEASED (Type or Print) a. (First) <b>Silas C</b> b. (Middle) <b>Fox</b> c. (Last) _____			4. DATE OF DEATH (Month) (Day) (Year) <b>7 22 - 1953</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Mar</b>	8. DATE OF BIRTH <b>7-10-1898</b>	9. AGE (In years last birthday) <b>75</b>	10. IF UNDER 1 YEAR Months <b>0</b> Days <b>12</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farming</b>		10b. KIND OF BUSINESS OR INDUSTRY _____	11. BIRTHPLACE (City and State or Foreign Country) <b>Marion Co Ind.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13a. FATHER'S NAME <b>Geo H Fox</b>		13b. MOTHER'S MAIDEN NAME <b>Emeline Zellers</b>	14. NAME OF HUSBAND OR WIFE <b>Don't know</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>unknown</b>		16. SOCIAL SECURITY NO. <b>DK</b>	17. INFORMANT'S SIGNATURE OR NAME <b>Ed Hatcher</b>		ADDRESS <b>St James Mo</b>
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.			<b>MEDICAL CERTIFICATION</b>		INTERVAL BETWEEN ONSET AND DEATH <b>0</b>
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Coronary Occlusion</b>			DUE TO (b) <b>Arteriosclerosis about</b>		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (c) _____			_____		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			_____		
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION <b>4201</b>			
21a. ACCIDENT SUICIDE HOMICIDE (Specify) _____		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) _____		
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m. _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? _____		
22. I hereby certify that I attended the deceased from <b>March 13/1952</b> to <b>July 22/1953</b> that I last saw the deceased alive on <b>July 19/1953</b> and that death occurred at <b>2:00 p.m.</b> , from the causes and on the date stated above.					
23a. SIGNATURE <b>C.V. Hammler, M.D.</b>			23b. ADDRESS <b>St. James, Mo</b>		23c. DATE SIGNED <b>7-23/53</b>
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	24b. DATE <b>7-23-53</b>	24c. NAME OF CEMETERY OR CREMATORY <b>Dexter</b>		24d. LOCATION (City, town, or county) (State) <b>Dexter Mo</b>	
DATE REC'D BY LOCAL REG. <b>7-23-53</b>		REGISTRAR'S SIGNATURE <b>Ruth B. Pritchard</b>	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>Oral Luckholder St James Mo</b>		

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 \_\_\_\_\_

*me*

Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student .....  
Student Embalmer

Signed

*Orville E. Lickliter*

Licensed Embalmer No. *3546*

P. O. Address *St James*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to complete the above constitutes grounds for revocation of license.)

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