

Dr. H. Silsby  
FILED NOV 4 1957

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

35486  
STATE FILE NUMBER  
Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 1041

S. 300  
1-57

1. PLACE OF DEATH a. COUNTY <b>Greene</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. <b>Missouri</b> b. COUNTY <b>Greene</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Springfield</b>		c. CITY OR TOWN <b>Springfield</b> <sup>2396</sup>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>1330 Cherry</b>		d. STREET ADDRESS (If outside, give location) <b>1330 Cherry</b>	
Length of stay in 1b <b>80 Yrs.</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
Reside on Form Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			

3. NAME OF DECEASED (Type or print) First <b>ADA</b> Middle Last <b>PATTERSON</b>			4. DATE OF DEATH Month <b>Oct.</b> Day <b>25</b> Year <b>1957</b>		
--	--	--	--	--	--

5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 17 ? About '80</b>	9. AGE (In years last birthday) <b>76</b>	10. F UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS. Hours Min.
-------------------------	----------------------------------	---	--	--	-----------------------------------	------------------------------------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Home</b>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <b>Springfield, Mo.</b>	12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
--	-----------------------------------	---	--

13a. FATHER'S NAME <b>(Unknown)</b>	13b. MOTHER'S MAIDEN NAME <b>(Unknown)</b>	14. NAME OF HUSBAND OR WIFE <b>Roscoe Patterson (Dec.)</b>
--	---	---

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>	16. SOCIAL SECURITY NO. <b>No</b>	17. INFORMANT <b>Hadley Patterson</b>	Address <b>Springfield, Mo.</b>
--	--------------------------------------	--	------------------------------------

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Stroke</b>		INTERVAL BETWEEN ONSET AND DEATH <b>3 months</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>Arteriosclerotic Cerebral Vascular disease.</b>		<b>10 years</b>
DUE TO (c)		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Neurofibromatosis</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>

20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
---	--

20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.	20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION <b>Springfield Greene Mo.</b>	COUNTY <b>Greene</b>	STATE <b>Mo.</b>
---	---	--	---	-------------------------	---------------------

21. I attended the deceased from <b>Mar 21, '49</b> to <b>Oct 20, '57</b> and last saw her alive on <b>Oct 10, '57</b> Death occurred at <b>12:45 a.m.</b> on the date stated above; and to the best of my knowledge, from the causes stated.
--

22a. SIGNATURE <b>H. Silsby M.D.</b> (Degree or title)	22b. ADDRESS <b>609 Cherry St.</b>	22c. DATE SIGNED <b>Oct 25, 57</b>
---	---------------------------------------	---------------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>10/26/57</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Maple Park</b>	23d. LOCATION (City, town, or county) (State) <b>Springfield, Mo.</b>
--	------------------------------	---	--

24. FUNERAL DIRECTOR <b>H.H. Lohmeyer</b>	ADDRESS <b>Springfield, Mo.</b>	25. DATE RECD. BY LOCAL REG. <b>10-25-57</b>	26. REGISTRAR'S SIGNATURE <b>Edith Williams</b>
--	------------------------------------	---	--

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

NOV 15 1957

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 ....., Student Embalmer No. .... working under my personal supervision.

Student .....  
Signature of Student Embalmer

Signed *R. J. McCann* .....

Licensed Embalmer No. *2729* .....

P. O. Address *Springfield, 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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.

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