

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-043768

STATE FILE NUMBER

FILED JAN 12 1959 Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 5

1-57
Don J. Silsby, M.D.

1. PLACE OF DEATH a. COUNTY <u>Greene</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Lawrence</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Springfield</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Miller</u> 0550 Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Baptist Hospital</u>		Length of stay in lb <u>5 days</u>	d. STREET ADDRESS <u>R.F.D. # 2</u> (If outside, give location) Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>Corea</u> Middle _____ Last <u>Bryant</u>			4. DATE OF DEATH Month <u>12</u> Day <u>30</u> Year <u>1958</u>		
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5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4-28-1880</u>	9. AGE (In years last birthday) <u>78</u>	IF UNDER 1 YEAR Months <u>8</u> Days <u>2</u>	IF UNDER 24 HRS. Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Keeper</u>	10b. KIND OF BUSINESS OR INDUSTRY _____	11. BIRTHPLACE (City and state or country) <u>Lawrence Co. O</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
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13a. FATHER'S NAME <u>C.W.B. Webb</u>	13b. MOTHER'S MAIDEN NAME <u>Mary Ann Morgan</u>	14. NAME OF HUSBAND OR WIFE <u>Deceased</u>
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>No</u>	16. SOCIAL SECURITY NO. _____	17. INFORMANT <u>Mrs. Thelma Prichard</u> Address _____
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebrovascular thrombosis</u> <u>acute</u>		INTERVAL BETWEEN ONSET AND DEATH <u>6 days</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (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)		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.) <u>332x</u>
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20c. TIME OF INJURY Hour _____ a.m. _____ p.m. _____	20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE 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 _____ COUNTY _____ STATE _____
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21. I attended the deceased from <u>Dec 25, '58</u> to <u>Dec 30, '58</u> and last saw her alive on <u>12/29/58</u> Death occurred at <u>1:30</u> <u>A.M.</u> on the date stated above; and to the best of my knowledge from the causes stated.	
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22a. SIGNATURE (Degree or title) <u>Don J. Silsby M.D.</u>	22b. ADDRESS <u>Springfield, Mo</u>	22c. DATE SIGNED <u>1-3-59</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>1-1-1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Webb</u>	23d. LOCATION (City, town, or county) (State) <u>S.M. of Miller Mo.</u>
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24. FUNERAL DIRECTOR <u>Morris - Leman</u>	ADDRESS <u>Miller Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>1-5-59</u>	26. REGISTRAR'S SIGNATURE <u>Effie & Melton</u>
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USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

social, cancer, etc.; must use any standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

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 *E. R. Leiman*

Licensed Embalmer No. *3297*

P. O. Address *Miller 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.