

**FRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**

**-60-038104**

Dr. H. Silsby

Registration District No. 128

Primary Registration District No. 2000

Registrar's No. 1080

STATE FILE NUMBER

FILED VS OCT 31 1960

1. PLACE OF DEATH a. COUNTY <b>GREENE</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <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>	
Length of stay in 1b		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>641 W. BROWER</b>		d. STREET ADDRESS (If outside, give location) <b>641 W. BROWER</b>	
Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <b>EDWARD</b> Middle <b>F.</b> Last <b>WOOD</b>			4. DATE OF DEATH Month <b>OCT.</b> Day <b>25</b> Year <b>1960</b>			
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5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>10/31/92</b>	9. AGE (last birthday) <b>67</b>	IF UNDER 1 YEAR Months	IF UNDER 24 HR Days	Hours	Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED</b>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <b>Terre Haute, Ind.</b>	12. CITIZEN OF WHAT COUNTRY <b>USA</b>
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13a. FATHER'S NAME <b>Frank B. Wood</b>	13b. MOTHER'S MAIDEN NAME <b>Hattie O. Daugherty</b>	14. NAME OF HUSBAND OR WIFE <b>NELLIE WOOD</b>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>YES W.W. # 1</b>	16. SOCIAL SECURITY NO. <b>311-03-2425</b>	17. INFORMANT <b>MRS. NELLIE WOOD, SPRINGFIELD, MO</b>	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:		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) <b>Congestive heart failure</b>		<b>4 years</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <b>Chronic myocarditis</b>	<b>Unknown</b>
	DUE TO (c) <b>Atherosclerotic vascular disease</b>	<b>Unknown</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Emphysema</b>		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown

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.)
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20c. TIME OF INJURY Hour a.m. p.m.	Month, Day, Year
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20d. INJURY OCCURRED WHILE AT WORK <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</b> COUNTY <b>Greene</b> STATE <b>MO</b>
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21. I attended the deceased from <b>Jan. 5, 1957</b> to <b>Oct. 29, 60</b> and last saw her/him alive on <b>Sept. 13, 60</b> Death occurred at <b>11:45 A.M.</b> on the date stated above, and to the best of my knowledge, from the causes stated.
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22a. SIGNATURE <i>H. Silsby M.D.</i> (Degree or title)	22b. ADDRESS <b>609 Cherry St</b>	22c. DATE SIGNED <b>Oct 25 60</b>
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23a. BURIAL, CREMATION, OR OTHER REMOVAL (Specify) <b>BURIAL</b>	23b. DATE <b>10/28/60</b>	23c. NAME OF CEMETERY OR CREMATORY <b>NATIONAL</b>	23d. LOCATION (City, town, or county) (State) <b>SPRINGFIELD, MO.</b>
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24. FUNERAL DIRECTOR ADDRESS <b>H.H. LOHMEYER FUNERAL HOME</b> <b>SPRINGFIELD, MO.</b>	25. DATE RECD. BY LOCAL REG. <b>10-26-60</b>	26. REGISTRARS SIGNATURE <i>Effie E. Melton</i>
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(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

NOV 4 1960  
NOV 1 1960

NOV 9 1960

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed R. L. M. Carr

Licensed Embalmer No. 272

P. O. Address Springer

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to  
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.