

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-044873

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 11848 STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

**FILED DEC 14 1962**

VS 300  
Rev. 4/59

1

2 8/20/7

3

4

5

6

7

8

9

10

11

12 68-0

13

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

|   |  |   |  |   |  |   |  |                             |  |   |  |  |  |  |  |
|---|--|---|--|---|--|---|--|-----------------------------|--|---|--|--|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY  |  | b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR TOWN                                      |  | Length of stay in 1b  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE |  | b. COUNTY                   |  | c. CITY OR TOWN   |  | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |  |  |  |
| c. FULL NAME OF (If NOT in hospital, give location)<br>HOSPITAL OR INSTITUTION  |  | Missouri Baptist Hosp   |  | Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>   |  | d. STREET ADDRESS   |  | 3201 Yale                   |  | Reside on Farm<br>Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>   |  |  |  |  |  |
| 3. NAME OF DECEASED (Type or print)   |  |   |  | First   |  | Middle  |  | Last                        |  | 4. DATE OF DEATH  |  | Month Day Year   |  |  |  |
| Lillian   |  |   |  | Sillman   |  |   |  |                             |  | Dec 7, 1962   |  |  |  |  |  |
| 5. SEX  |  | 6. COLOR OR RACE  |  | 7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/><br>Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> |  | 8. DATE OF BIRTH  |  | 9. AGE (last birthday)      |  | IF UNDER 1 YEAR   |  | IF UNDER 24 HR   |  |  |  |
| Female  |  | Cau.  |  |   |  | 3-26-02   |  | 60                          |  | Months Days   |  | Hours Min.   |  |  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)   |  |   |  | 10b. KIND OF BUSINESS OR INDUSTRY   |  | 11. BIRTHPLACE (City and state or country)  |  | 12. CITIZEN OF WHAT COUNTRY |  |   |  |  |  |  |  |
| Housewife   |  |   |  | Home  |  | Potosi, Missouri  |  | U.S.A.                      |  |   |  |  |  |  |  |
| 13a. FATHER'S NAME  |  |   |  | 13b. MOTHER'S MAIDEN NAME   |  |   |  | 14. NAME OF HUSBAND OR WIFE |  |   |  |  |  |  |  |
| William Yearbrough  |  |   |  | Louise Sours  |  |   |  | Harold Sillman              |  |   |  |  |  |  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) (If yes, give war or dates of service)   |  |   |  | 16. SOCIAL SECURITY NO.   |  | 17. INFORMANT   |  | Address                     |  |   |  |  |  |  |  |
| No  |  |   |  | Unknown   |  | Harold Sillman  |  | 3201 Yale Collinville, Ill. |  |   |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:  |  |   |  |   |  |   |  |                             |  |   |  | INTERVAL BETWEEN ONSET AND DEATH   |  |  |  |
| IMMEDIATE CAUSE (a)   |  |   |  |   |  |   |  |                             |  |   |  | 1957   |  |  |  |
| DUE TO (b)  |  |   |  |   |  |   |  |                             |  |   |  |  |  |  |  |
| DUE TO (c)  |  |   |  |   |  |   |  |                             |  |   |  | 443x   |  |  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)   |  |   |  |   |  |   |  |                             |  | PART III. If deceased was female was there a pregnancy in last 90 days.<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown |  |  |  |  |  |
| 19. WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input 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 a.m. p.m.  |  | Month, Day, Year  |  |   |  |                             |  |   |  |  |  |  |  |
| 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  |  | COUNTY  |  | STATE                       |  |   |  |  |  |  |  |
| 21. I attended the deceased from <u>James</u> - 59 to <u>Dec 7 - 62</u> and last saw her <u>live on Dec 7 - 62</u><br>Death occurred at <u>2:30</u> P.M. on the date stated above, and to the best of my knowledge, from the causes stated. |  |   |  |   |  |   |  |                             |  |   |  |  |  |  |  |
| 22a. SIGNATURE (Degree or title)  |  |   |  |   |  | 22b. ADDRESS  |  |                             |  | 22c. DATE SIGNED  |  |  |  |  |  |
| <u>W. D. Brown M.D.</u>   |  |   |  |   |  | <u>3903 Olive</u>   |  |                             |  | <u>12/8/62</u>  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   |  | 23b. DATE   |  | 23c. NAME OF CEMETERY OR CREMATORY  |  | 23d. LOCATION (City, town, or county) (State)   |  |                             |  |   |  |  |  |  |  |
| Removal   |  | 12-11-62  |  | Bethlehem Cemetery  |  | Bethlehem, Missouri   |  |                             |  |   |  |  |  |  |  |
| 24. FUNERAL DIRECTOR ADDRESS  |  |   |  | 25. DATE RECD. BY LOCAL REG.  |  | 26. REGISTRAR'S SIGNATURE   |  |                             |  |   |  |  |  |  |  |
| <u>McLaughlin 2301 Lafayette Ave (4) St. Louis, Mo.</u>   |  |   |  | DEC 11 1962   |  | <u>Adair Smith, M.D.</u>  |  |                             |  |   |  |  |  |  |  |

STATE OF OHIO

**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 James R. Chapman

Licensed Embalmer No. 4550

P. O. Address St. Louis, 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.