

**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

Do not use this space.

8983

PR 27 1927

1. PLACE OF DEATH

County Mississippi
Township Ohio
City Phillip (No.) (Ward)

Registration District No. 569
Primary Registration District No. 5765

File No.
Registered No.

2. FULL NAME

Phillip Rathchild

(a) Residence. No. St. Ward.
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Married

5a. If MARRIED, WIDOWED, OR DIVORCED
HUSBAND of Bythe Dinty Rathchild
(or) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR) April 20 1877

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
49 11 8

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) Missouri
(STATE OR COUNTRY)

PARENTS

10. NAME OF FATHER Simon Rathchild

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Mo
(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER Winnie Kelly

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Mo
(STATE OR COUNTRY)

14. INFORMANT X O P Brown
(Address) Wyatt, Mo.

15. FILED March 28 1927 A. Marshall
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 3/28 1927

17. I HEREBY CERTIFY, That I attended deceased from March 28, 1927, to March 28, 1927 that I last saw him alive on March 25, 1927, and that death occurred, on the date stated above, at 7:05 P. m.

THE CAUSE OF DEATH WAS AS FOLLOWS:
Paralysis
81A

CONTRIBUTORY (SECONDARY) Malaria
(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH, DATE OF

0 DID AN OPERATION PRECEDE DEATH? no DATE OF

WAS THERE AN AUTOPSY? no

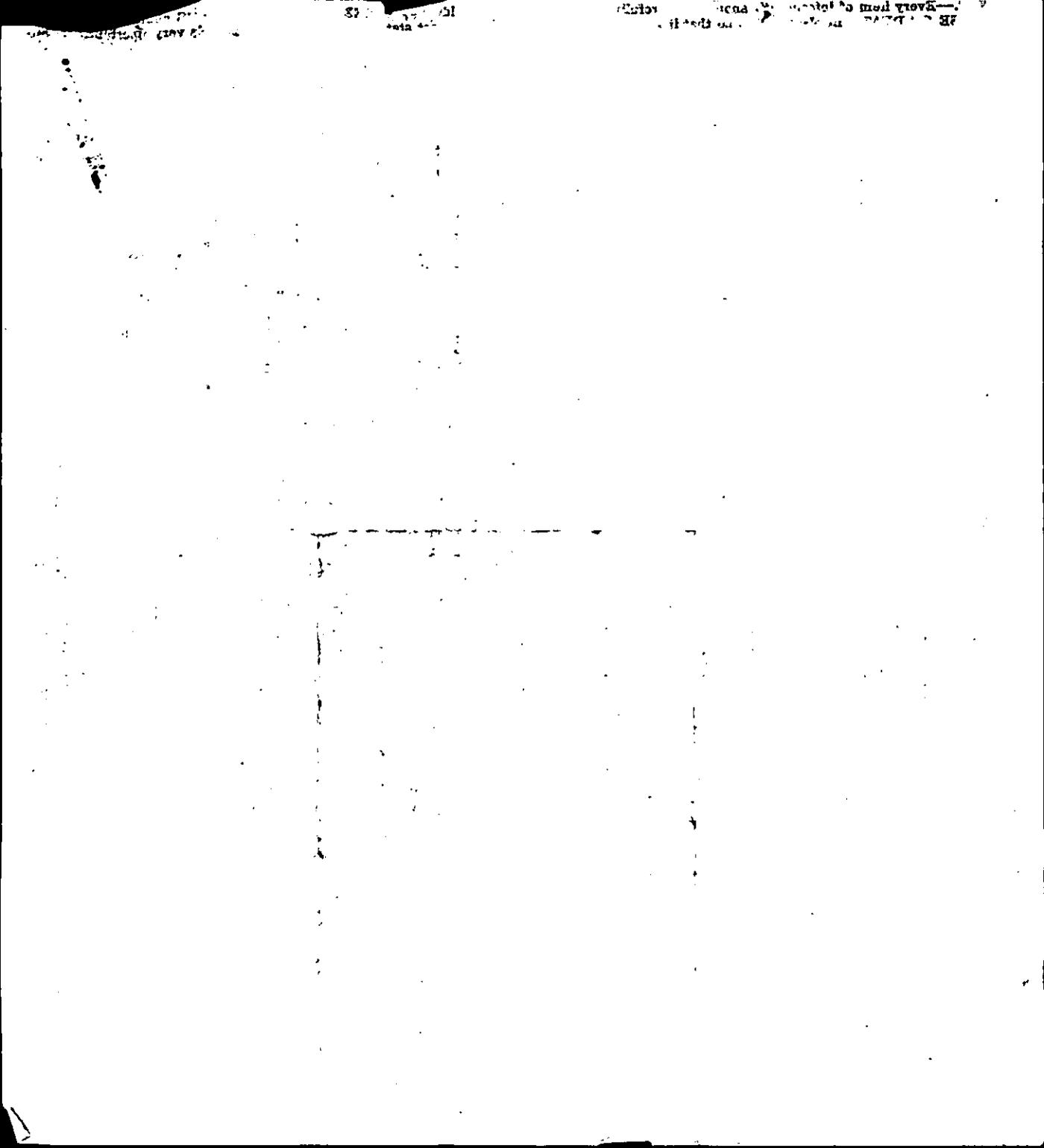
WHAT TEST CONFIRMED DIAGNOSIS? none
(Signed) A. Marshall, M. D.

(Address) Wyatt Mo
*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Dak Grove DATE OF BURIAL 3/29 1927

20. UNDERTAKER The Fair Salvage Co ADDRESS Charleston Mo
1110

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.



**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

ALL INFORMATION CALLED
FOR MUST BE WRITTEN ON
THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County Miss
Towship Ohio
City (No. St. Ward)

Registration District No. 569
Primary Registration District No. 5-765-

File No.
Registered No.

2. FULL NAME

Phillip Rathchild

(a) Residence. No. St. Ward.
(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

m

4. COLOR OR RACE

w

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)

m

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

7. AGE

YEARS

MONTHS

DAYS

If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employee)

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN)

(STATE OR COUNTRY)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY)

14. INFORMANT
(Address)

15. 5/18/27 19 airmarsh
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR)

3-28 19 27

17.

I HEREBY CERTIFY, That I attended deceased from to, 19

and I last saw him alive on, 19, and that death occurred, on the date stated above, at

THE CAUSE OF DEATH* WAS AS FOLLOWS:

paratyphoid ascending

(duration) yrs. mos. ds.

CONTRIBUTORY Malaria
(SECONDARY)

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF BIRTH

DID AN OPERATION PRECEDE DEATH? DATE OF

WAS THERE AN AUTOPSY?

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed), M. D.

, 19 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL

DATE OF BURIAL

19

20. UNDERTAKER

ADDRESS

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

N. B.—Every item of information should be carefully supplied. AGE should be EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very

SUPPLEMENTARY

S-8983