

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

Do not use this space.

31903

1. PLACE OF DEATH

County..... Registration District No. **791**
 Township..... Primary Registration District No. **1003**
 City **St. Louis** (No. **city Infirmary**)

File No.
 Registered No. **19267**
 St. Ward)

2. FULL NAME

Walter Phillips
 (a) Residence. No. St. **13** Ward.
 (Usual place of abode) **city Infirmary** (If nonresident give city or town and State)
 Length of residence in city or town where death occurred **61** yrs. **7** mos. **13** da.) How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **m** 4. COLOR OR RACE **Colored** 5. SINGLE, MARRIED, (WIDOWED) OR DIVORCED **Widowed**
 (write the word)
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF **?**
 6. DATE OF BIRTH (MONTH, DAY AND YEAR) **Sept 1866**

YEARS	MONTHS	DAY	IF LESS than 1 day, hrs. or min.
61	?	?	

8. OCCUPATION OF DECEASED
 (a) Trade, profession, or particular kind of work **Labour**
 (b) General nature of industry, business, or establishment in which employed (or employer)
 (c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) **mo**
 (STATE OR COUNTRY)

PARENTS
 10. NAME OF FATHER **Joe Phillips**
 11. BIRTHPLACE OF FATHER (CITY OR TOWN) **mo**
 (STATE OR COUNTRY)
 12. MAIDEN NAME OF MOTHER **Malinda**
 13. BIRTHPLACE OF MOTHER (CITY OR TOWN) **mo**
 (STATE OR COUNTRY)

14. INFORMANT **Minnie Shelton**
 (Address) **715 N Channing**

15. FILED **NOV 18 1927** **Max B. Starckoff**
 REGISTRAR

2 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) **Oct 15 1927**
 17. I HEREBY CERTIFY, That I attended deceased from **Sept 30**, 1927, to **Oct 15**, 1927, and that I last saw him alive on **Oct 15**, 1927, and that death occurred, on the date stated above, at **10:00** A.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Cerebral Hemorrhage

700
 (duration) yrs. mos. da.
 CONTRIBUTORY **ch. myocarditis**
 (SECONDARY)
 (duration) yrs. mos. da.

18. WHERE WAS DISEASE CONTRACTED **?**
 IF NOT AT PLACE OF DEATH?

19. DID AN OPERATION PRECEDE DEATH? **no** DATE OF.....
 WAS THERE AN AUTOPSY? **no**

WHAT TEST CONFIRMED DIAGNOSIS? **clinical test**
 (Signed) **Kenneth L. Howard** M. D.
 , 19 (Address) **city Hospital**

*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 **Bridgeton** DATE OF BURIAL **10/23 1927**

20. UNDERTAKER **C. W. Roberts** ADDRESS **3035 Lucas**

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

