

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

Do not use this space.

1. PLACE OF DEATH

County Jackson

Registration District No. 398

Township Independence

Primary Registration District No. 3019

File No. 13148
Registered No. 148
St. _____ Ward _____

2. FULL NAME

Becilia Phillips

(a) Residence. No. 1106 W. Washington 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

Female

4. COLOR OR RACE

White

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

Widowed

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

Widowed

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

Apr 4 - 1845

7. AGE

YEARS 83

MONTHS 1

DAY 13

If LESS than 1 day, _____ hrs. or _____ min.

8. OCCUPATION OF DECEASED

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

House work

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

At Home

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN)

Cleveland

(STATE OR COUNTRY)

Ohio

10. NAME OF FATHER

W^m Brown

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

Unknown

(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER

Lidia Hardy

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

Unknown

(STATE OR COUNTRY)

14.

INFORMANT

Francis R. Phillips

(Address)

Mount Washington

15.

FILED

4/24 1928

F. L. COOK

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

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

April 17 1928

17. I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____, and that I last saw him _____ alive on _____, 19____, and that death occurred, on the date stated above, at _____, _____, _____, Mo.

Shady Center
7:00 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Chronic Myocarditis

CONTRIBUTORY (SECONDARY)

930
97
Arterio Sclerosis (duration) _____ yrs. _____ mos. _____ ds.

18. WHERE WAS DISEASE CONTACTED

IF NOT AT PLACE OF DEATH _____

19. DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____

20. WAS THERE AN AUTOPSY? _____

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed) Ed. Garrison & Son, M. D.

4/18-1928 (Address) Shady Center

*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

DATE OF BURIAL

Mount Grove

4-18 1928

20. UNDERTAKER

ADDRESS

Ed. Garrison & Son

Independence

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.

1928

