

25 1929

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

Do not use this space.
28244

1. PLACE OF DEATH

County Washington
Township _____
City _____ (No. _____ St. _____ Ward _____)

Registration District No. H64
Primary Registration District No. 5626

File No. 18
Registered No. 43

2. FULL NAME Dolly Haver Phillips

(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 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 John Phillips

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Sept 28 - 1878

7. AGE YEARS MONTHS Days If LESS than 1 day, ____ hrs. or ____ min.
55 10 17

8. OCCUPATION OF DECEASED

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

9. BIRTHPLACE (CITY OR TOWN) Alma Mo
(STATE OR COUNTRY)

10. NAME OF FATHER James H Haver

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

12. MAIDEN NAME OF MOTHER Felicita Vogel

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

14. INFORMANT (Address) P J Wanner
Poplar St

15. Sept 10, 1929 W. H. Croley
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Aug 9 - 1929

17. I HEREBY CERTIFY, That I attended deceased from June 2 1929, to Aug 9 - 1929 that I last saw her alive on Aug 1, 1929, and that death occurred, on the date stated above, at 2:30 P m.

THE CAUSE OF DEATH WAS AS FOLLOWS:

Multiple Sarcoma
50

CONTRIBUTORY (SECONDARY) None

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

1 DID AN OPERATION PRECEDE DEATH. Yes DATE OF Unknown

WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS? None
(Signed) Proper Williams, M. D.

8/10 1929 (Address) Mayview, 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 Memorial Chop DATE OF BURIAL 8/10 1929

20. UNDERTAKER Adolph ADDRESS Wagonville

121

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ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County Douglas Registration District No. 464 File No. 18
 Township Washington Primary Registration District No. 3-626 Registered No. 43
 City St. Louis (No. 1) St. 18 Ward 43

2. FULL NAME

(a) Residence. No. Sally W. Phillips St. 18 Ward 43
 (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 F 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Wed

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,hr. ormin.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... (duration)yrs.mos.ds.
 (b) General nature of industry, business, or establishment in which employed (or employer).....
 (c) Name of employer.....

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

PARENTS
 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. FILED 9/10/29 R. Schooley REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Aug 9 1929

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

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Multiple Sarcoma
Left Breast
 (duration)yrs.mos.ds.

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

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH.....

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.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL DATE OF BURIAL

20. UNDERTAKER ADDRESS

SUPPLEMENTARY

SH282-S