

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.

Registration District No. 784A

Primary Registration District No. 117

Registrar's No. 1169

1. PLACE OF DEATH:
 (a) County St. Louis,
 (b) City or town Webster Groves
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: 446 Foote Ave.,
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution _____
 (Specify whether _____)
 In this community _____
 years, months or days _____

3. (a) PRINT FULL NAME Cora H. Phillips
 3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Single
 6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
 7. Birth date of deceased April 6, 1868
 (Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>71</u>	<u>2</u>	<u>24</u>	_____ hr. _____ min.

9. Birthplace Missouri
 (City, town, or county) (State or foreign country)
 10. Usual occupation Housekeeper

11. Industry or business _____
 MOTHER FATHER { 12. Name John W. Phillips
 18. Birthplace Penn.
 (City, town, or county) (State or foreign country)
 14. Maiden name _____
 15. Birthplace Ohio.
 (City, town, or county) (State or foreign country)

16. (a) Informant's own signature Mrs. K. Schaal
 (b) Address 6131 Lalite
 17. (a) Burial (b) Date thereof 7/3/39
 (Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation Mt. Lebanon Cemetery

18. (a) Signature of funeral director Dickson Hall
 (b) Address 1905 Union Blvd.
 19. (a) JUL - 1 1939 (b) T. C. Meyer, M.D.
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
 (a) State Mo. (b) County St. Louis
 (c) City or town Webster Groves, Mo.
 (If outside city or town limits, write "RURAL")
 (d) Street No. 446 Foote St.
 (If rural, give location)
 (e) If foreign born, how long in U. S. A. ? _____ years.

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month June day 30
 year 1939 hour one minute 25 P.M.
 21. I hereby certify that I attended the deceased from 6/30/39, 19, to 6/30/39, 19;
 that I last saw her alive on 6/30/39, 19;
 and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Hemorrhage Duration ?
 Due to Arteriosclerosis & Hypertension
 Due to 8721
 Other conditions Hypertension B/P. 220
 (Include pregnancy within months of death)

PHYSICIAN
 Major findings: Of operations none
 Of autopsy none
 Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
 (a) Accident, suicide, or homicide (specify) none
 (b) Date of occurrence _____
 (c) Where did injury occur? _____ (City or town) (County) (State)
 (d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work? _____ (Specify type of place) (e) Means of injury _____
 23. Signature Frank P. Sant, M.D. (M. D. or other)
 Address 13th N. Gore, Webster Groves Date signed 6/30/39

16 H. FIVE OUT

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.....
....., Registered Apprentice No.....
working under my personal supervision.

Signed R. M. Sanford
Licensed Embalmer No. 2273
P. O. Address St. Louis

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 this body is not embalmed, above space should be left blank.