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FILED AUG 9 1940

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

Dr. F. Camp 25176

State File No.

Registration District No. 318 Primary Registration District No. 2001 Registrar's No. 563

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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(a) County Greene

(b) City or town Springfield
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: St. John Hosp. 1
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 4 days (Specify whether
In this community years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Greene

(c) City or town Springfield 0
(If outside city or town limits write "RURAL")

(d) Street No. 934 E. Elm
(If rural, give location)

(e) If foreign born, how long in U. S. A.? years.

3. (a) PRINT FULL NAME Eugene W. Phillips 412

3. (b) If veteran, name war no

3. (c) Social Security No. None

4. Sex Male

5. Color or race White

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Alice Phillips

6. (c) Age of husband or wife if alive 69 years

7. Birth date of deceased June (Month) 19 (Day) 1868 (Year)

8. AGE: Years 72 Months 0 Days 18 If less than one day hr. min.

9. Birthplace Grigsville (City, town, or county) Illinois (State or foreign country)

10. Usual occupation Salesman

11. Industry or business Insurance Agency

FATHER
12. Name Tom Phillips
13. Birthplace Unknown (City, town, or county) Unknown (State or foreign country)

MOTHER
14. Maiden name Sarah Unknown
15. Birthplace Unknown (City, town, or county) Unknown (State or foreign country)

16. (a) Informant Fred Phillips Jr.
(b) Address Springfield, Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof July 9 1940 (Month) (Day) (Year)
(c) Place: burial or cremation Hazelwood

18. (a) Signature of funeral director H.H. Lohmeyer 984
(b) Address Springfield, Mo.

19. (a) July 9, 1940 (Date received local registrar) (b) W. E. Handley MD (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 7
year 1940 hour 3 minute p. M.

21. I hereby certify that I attended the deceased from June 1, 1940 to July 7, 1940
that I last saw him alive on July 7, 1940
and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Ac Glomerulo-nephritis	1 mo.
Due to	
Due to	
Other conditions none (Include pregnancy within 3 months of death)	
Major findings: Of operations none	
Of autopsy none	

PHYSICIAN
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)
(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? (Specify type of place)
While at work (e) Means of injury

23. Signature Francis B. Camp (M. D. or other)
Address Springfield Mo. Date signed July 8 40

(Licensed Embalmer's Statement on Reverse Side)

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

Signed M. L. Canaday

Licensed Embalmer No. 3424

P. O. Address Springfield, Mo.

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.

X

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21-40
X22659

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State File No. 28-176

Registration District No. 318 Primary Registration District No. 2001 Registrar's No. 563

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

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

3. (a) PRINT FULL NAME Eugene W. Phillips
3. (b) If veteran, name war
3. (c) Social Security No.

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

8. AGE: Years 72 Months 0 Days 18 If less than one day hr. min.

9. Birthplace (City, town, or county) (State or foreign country)
10. Usual occupation
11. Industry or business
FATHER 12. Name
13. Birthplace (City, town, or county) (State or foreign country)
MOTHER 14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)
16. (a) Informant
(b) Address
17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation
18. (a) Signature of funeral director
(b) Address
19. (a) 9-12-40 (Date received local registrar) (b) W. E. Hundley MD (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 7 year 1940 hour minute M.
21. I hereby certify that I attended the deceased from , 19, to , 19; that I last saw him alive on , 19; and that death occurred on the date and hour stated above.

Immediate cause of death: Glomerular Nephritis — Duration
Due to: Chronic Nephritis
Due to:
Other conditions (Include pregnancy within 3 months of death)
Major findings:
Of operations
Of autopsy

PHYSICIAN — 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)
(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? (Specify type of place)
While at work? (e) Means of injury

23. Signature Francis B. Camp (M. D. or other)
Address Springfield Mo Date signed

SUPPLEMENTARY