

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

State File No. _____

Registration District No. 308

Primary Registration District No. 3026

Registrar's No. 95

1. PLACE OF DEATH:

(a) County Livingston

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

(c) Name of hospital or institution:
Chillicothe Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 5 Days
(Specify whether _____)

In this community 20 yrs.
years, months or days)

3. (a) PRINT FULL NAME Alice C. Phillips 412

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 Widow

6. (b) Name of husband or wife William R. Phillips

6. (c) Age of husband or wife If alive - years

7. Birth date of deceased Oct. 5 1869
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day

70 9 10 - hr. - min.

9. Birthplace Carroll Co. Mo.
(City, town, or county) (State or foreign country)

10. Usual occupation At Home

11. Industry or business _____

MOTHER FATHER { 12. Name William Herrick 1

13. Birthplace New Hamps
(City, town, or county) (State or foreign country)

14. Maiden name Chloe M. Jones

15. Birthplace New Hampsh
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Marshall Purcell

(b) Address Chillicothe, Missouri

17. (a) Burial (b) Date thereof July 22 1940
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Plymouth, Mo

18. (a) Signature of funeral director Jamert Gordon

(b) Address Chillicothe Missouri

19. (a) 7-22-40 (b) Arnold M.D.
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County Livingston

(c) City or town Chillicothe - RURAL
(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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 20
year 1940 hour 9 minute 45 P.M.

21. I hereby certify that I attended the deceased from July 15
1940 to July 20 1940

that I last saw her alive on July 20 1940
and that death occurred on the date and hour stated above.

Immediate cause of death apoplexy

Due to Cerebral Hemorrhage

Duration
6 days

Other conditions HTN
(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) no

(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?
943
(Specify type of place) _____

While at work? _____ (e) Means of injury _____

23. Signature P. A. Brennan (M. D. or other)
Address Chillicothe, Mo Date signed 7/22/40

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.

RECEIVED

District Health Officer No. 11;

District File Number 840-1069

Date Filed AUG 9 1940

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 James D. Gordon

Licensed Embalmer No. 1870

P. O. Address Chillicothe, 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.