

Registration District No. 460

Primary Registration District No. 4274

Registrar's No. 45

1. PLACE OF DEATH: Lafayette

(a) County: Lafayette

(b) City or town: Higginsville, 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 2  
In this community: Eight years (Specify whether years, months or days)

3. (a) PRINT FULL NAME: Elmer Vest Phillips

3. (b) If veteran, name war: No.

3. (c) Social Security No.:

4. Sex: Male race: White

5. Color or race: White

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

6. (b) Name of husband or wife: Etta Lyle Phillips

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

7. Birth date of deceased: Feb 2nd 1879  
(Month) (Day) (Year)

8. AGE: Years 61 Months 7 Days 10  
If less than one day hr. min.

9. Birthplace: Near Fulton, Mo. 0  
(City, town, or county) (State or foreign country)

10. Usual occupation: Merchant Grocery 0

11. Industry or business: II II 0

MOTHER FATHER { 12. Name: David R. Phillips

13. Birthplace: Missouri.  
(City, town, or county) (State or foreign country)

14. Maiden name: Mary Francis Yoke

15. Birthplace: Missouri.  
(City, town, or county) (State or foreign country)

16. (a) Informant: Etta Lyle Phillips

(b) Address: Higginsville, Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: 9/15/40  
(Month) (Day) (Year)

(c) Place: burial or cremation: Higginsville, Mo.

18. (a) Signature of funeral director: J. N. Stader

(b) Address: Higginsville, Mo.

19. (a) 7-24-1940 (b) Tipping Webb  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State: Missouri (b) County: Lafayette

(c) City or town: Higginsville  
(If outside city or town limits, write "RURAL")

(d) Street No.: Main St.  
(If rural, give location)

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 12 day Sept.  
year 1940 hour minute M.

21. I hereby certify that I attended the deceased from 9-13-1940 to 9-13-1940  
that I last saw him alive on 1940 and that death occurred on the date and hour stated above.

Immediate cause of death: Suicide

Due to: Cut throat with knife

Other conditions: (Include pregnancy within 3 months of death) 16

Major findings: Of operations

Of autopsy: no.

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: about 9 PM

(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? 413  
While at work? (Specify type of place) (e) Means of injury

23. Signature: J. N. Stader (M. D. number) 1

Address: Osceola Mo Date signed: 9/15/40

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

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RECEIVED  
District Health Officer No. 8,  
District File Number 10-4-40  
Date Filed

**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 \_\_\_\_\_ *Donald K. Kelly*

Licensed Embalmer No. 3637

P. O. Address \_\_\_\_\_

**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.