

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. **38603**  
Registrar's No. **75**

Registration District No. **281**

Primary Registration District No. **6256**

1. PLACE OF DEATH:

(a) County Douglas  
(b) City or town Seymour Spencer  
(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 \_\_\_\_\_)  
In this community \_\_\_\_\_  
years, months or days \_\_\_\_\_

3. (a) PRINT FULL NAME John D. Philpott

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. None

4. Sex \_\_\_\_\_ 5. Color or race \_\_\_\_\_ 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Ethel Philpott 6. (c) Age of husband or wife if alive 52 years

7. Birth date of deceased July 27 1888  
(Month) (Day) (Year)

8. AGE: Years 52 Months 3 Days 23 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace Route Farmer# Seymour, Mo.  
(City, town, or county) (State or foreign country)

10. Usual occupation Farmer

11. Industry or business \_\_\_\_\_

12. Name William H. Philpott

13. Birthplace Webster Co., Mo.  
(City, town, or county) (State or foreign country)

14. Maiden name Louise Dennie

15. Birthplace Webster, Co. Mo  
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Lawrence W. Philpott

(b) Address Santa Clara, Calif.

17. (a) Burial (b) Date thereof 11-21-40  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Dogwood

18. (a) Signature of funeral director Clinkingbeard Funeral Home

(b) Address Ava, Mo.

19. (a) 11-26 1940 (b) Reba King White  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Douglas  
(c) City or town Seymour Rural  
(If outside city or town limits, write "RURAL")  
(d) Street No. Route 4.  
(If rural, give location)  
(e) If foreign born, how long in U. S. A. ? \_\_\_\_\_ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov. day 20  
year 1940 hour 10 minute 35 P. M.

21. I hereby certify that I attended the deceased from Nov 1 1940, 1940, to 11-20, 1940  
that I last saw him alive on 11-20, 1940  
and that death occurred on the date and hour stated above.

Immediate cause of death Toxemia  
Due to Coronary of Septe  
Due to Intestine

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

Major findings: \_\_\_\_\_  
Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

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?  
at home (Specify type of place) \_\_\_\_\_  
While at work? \_\_\_\_\_ (e) Means of injury \_\_\_\_\_

23. Signature M.C. Jenkins (M. D. or other) 1  
Address Ava Mo Date signed 11-21-40

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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. 6,  
District File Number

Date Filed DEC 3 1940

RECEIVED

District Health Officer No. 6,  
District File Number 1140-273

Date Filed DEC 3 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 V. B. Hutchison

Licensed Embalmer No. 3437

P. O. Address Gainesville, TX

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.

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

Registration District No. 281

Primary Registration District No. 6256

1. PLACE OF DEATH:

- (a) County Douglas
- (b) City or town Spearsville, Pa.  
(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 \_\_\_\_\_)
- In this community \_\_\_\_\_  
years, months or days

3. (a) PRINT FULL NAME

John D. Phelput

- 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 \_\_\_\_\_ year

7. Birth date of deceased \_\_\_\_\_ (Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>32</u>	<u>3</u>	<u>23</u>	_____ hr. _____ min.

9. Birthplace \_\_\_\_\_ (City, town, or county) (State or foreign country)

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

12. Name \_\_\_\_\_

13. Birthplace \_\_\_\_\_ (City, town, or county) (State or foreign country)

14. Maiden name \_\_\_\_\_ (City, town, or county) (State or foreign country)

15. Birthplace \_\_\_\_\_ (City, town, or county) (State or foreign country)

16. (a) Informant \_\_\_\_\_

(b) Address \_\_\_\_\_

17. (a) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_ (Month) (Day) (Year)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

19. (a) 11-26-1940 (b) Reba King White (Date received local registrar) (Registrar's signature)

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) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: month Nov day 20  
year \_\_\_\_\_ 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 \_\_\_\_\_

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_ (Include pregnancy within 3 months of death)

Major findings: Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

Duration

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? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place) (Name of injury)

23. Signature M. C. Gentry (M. D. or other) \_\_\_\_\_  
Address Law Mo. Date signed \_\_\_\_\_

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

SUPPLEMENTARY

