

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. **135**

Primary Registration District No. **3010**

Registrar's No. **119**

1. PLACE OF DEATH:

(a) County Carroll

(b) City or town Carrollton
(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 Marshall Alford Phipps

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex M. **5. Color or race** W

6. (a) Single, widow, 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 Nov. 17, 1940
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
	<u>1</u>	<u>14</u>	hr. min.

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

10. Usual occupation Infant

11. Industry or business _____

MOTHER FATHER

12. Name Orlando Alford Phipps

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

14. Maiden name Blauche Irene Macklin

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

16. (a) Informant's own signature Orlando Phipps

(b) Address Carrollton Mo

17. (a) (b) Date thereof 1-3-41
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Avon Mo

18. (a) Signature of funeral director Stanley

(b) Address Carrollton Mo

19. (a) (b) 1-2-1941 John Haskins
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Carroll

(c) City or town Carrollton
(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 Dec day 31
- year 1940 hour 4 minute 20 P. M.

21. I hereby certify that I attended the deceased from 12:30:40
_____, 19____, to 12:31, 19____;

that I last saw him alive on 12:31, 19____;

and that death occurred on the date and hour registered above.

Immediate cause of death Pneumonia Bronchial
Bi lateral /Duration
5 days

Due to _____

Due to _____

Other conditions _____
(Include pregnancy within 3 months of death)

PHYSICIAN

Major findings: _____

Of operations _____

Of autopsy _____

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? _____

23. Signature Emmett Bales (M. D. or other) 1940

Address Carrollton Mo Date signed Dec 1/40

107W

RECEIVED
District Health Officer No. 8,
District File Number 1-8-41
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 Ben W. Gibson

Licensed Embalmer No. 2961

P. O. Address Carrollton, Va

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

State File No. 42080

Registration District No. 135

Primary Registration District No. 2010

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Carroll
(b) City or town Carrollton
(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 Marshall Alford Phipps

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 s

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 Months Days If less than one day
1 14 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 _____

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) _____ (b) _____ (Registrar's signature)
(Date received local registrar)

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.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 31
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 Bilateral pneumonia (Pneumonia)

Due to Influenza (Duration 3 days)

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? _____

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

23. Signature Raymond Sals (M. D. or other) MD

Address Carrollton mo Date signed _____

SUPPLEMENTARY

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

MOTHER FATHER

1940
S-42080