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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **355863**

FILLED NOV 12 1941
Registration District No. **603**

Primary Registration District No. **4359**

Registrar's No. _____

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

1. PLACE OF DEATH *New Madrid*

(a) County *New Madrid*

(b) City or town *Catron, 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 _____)

In this community _____
years, months or days

2. USUAL RESIDENCE OF DECEASED: **72**

(a) State *Missouri* (b) County *New Madrid*

(c) City or town *Catron*
(If outside city or town limits, write "RURAL")

(d) Street No. _____ (If rural, give location) **0**

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

3. (a) PRINT FULL NAME **LETTER PHILLIPS**

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month *June* day *27*
year *1941* hour *8* minute *30 A.M.*

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
that I last saw him alive on *June 27*, 19____,
and that death occurred on the date and hour stated above.

4. Sex *M* 3 race *negro*

5. Color or race _____

6. (a) Single, widowed, married, divorced *0*

6. (b) Name of husband or wife _____

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

7. Birth date of deceased *June 20 1940*
(Month) (Day) (Year)

Immediate cause of death *Heart Knout*

Due to *10 min on a full minute after 1 minute*

Due to _____

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

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

1 7 hr. min.

9. Birthplace *Victoria Ark.*
(City, town, or county) (State or foreign country)

PHYSICIAN

Major findings: _____
Of operations _____

Of autopsy _____

Underline the cause to which death should be charged statistically.

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 12. Name *James C. Phillips*

13. Birthplace *Oceola Ark.*
(City, town, or county) (State or foreign country)

14. Maiden name *Barbara Robinson*

15. Birthplace *Oceola Ark.*
(City, town, or county) (State or foreign country)

16. (a) Informant *James Phillips*

(b) Address *Arion Mo.*

17. (a) *Burial* (b) Date thereof *6-27-41*
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation *Catron Mo.*

18. (a) Signature of funeral director *Watkins Funeral Service*

(b) Address *Arion Mo.*

19. (a) *10/31/41* (b) *Dr. G. W. Husted*
(Date received local registrar) (Registrar's signature)

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 *0*

23. Signature *G. N. Sherman* (M. D. *10/31/41*)
Address *Arion Mo.* Date signed _____

RECEIVED

District Health Office No. 2

District File Number 1141-1447

Date Filed 7/11/2/41

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.....

Licensed Embalmer No.....

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, fact should be so stated above.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 35586

Registration District No. 605

Primary Registration District No. 4359

Registrar's No. _____

1. PLACE OF DEATH:

(a) County New Madrid
(b) City or town Canton
(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)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County New Madrid
(c) City or town Canton
(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 _____

3. (a) PRINT FULL NAME Geetter Phillip
-3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month June Day 27 Year 1947 Hour _____ Minute _____ M.
21. I hereby certify that I attended the deceased from _____ 19____ to _____ 19____
that I last saw him _____ live on _____ 19____
and that death occurred on the date and hour stated above.

4. Sex M 5. Color or race B 6. (a) Single, widowed, married, divorced _____
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____

Immediate cause of death Heart know died 20 minutes after I arrived
Due to _____
Due to It is said or was Cancer

7. Birth date of deceased June 20, 1914
(Month) (Day) (Year)
8. AGE: 1 Year _____ Months 7 Days _____ If less than one day _____ min.

Other conditions (Include pregnancy within 3 months of death) are none, but I have
Major findings no information
Of operations pleural effusion
Of autopsy to be final
1-23-42

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

10. Usual occupation _____

11. Industry of business _____

MOTHER FATHER { 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)

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) 552
(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? _____

16. (a) Informant _____
(b) Address _____
17. (a) _____ (b) Date thereof _____ (Month) (Day) (Year)
(Burial, cremation, or removal) _____
(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____
(b) Address _____

While at work? _____ (Specify type of place) (c) Means of injury _____
23. Signature G. N. Wilson (M. D. or other) _____
Address Licksum Mo Date signed 7-2-47

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

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

SUPPLEMENT

PHYSICIAN
Underline the cause to which death should be charged statistically.

S-35586