

2
41
39

State File No. 5

Registration District No. 104281

Primary Registration District No. 4295

Registrar's No. 8

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

1. PLACE OF DEATH:

(a) County Kingsburg

(b) City or town Edwards

(c) Name of hospital or institution: 1

(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution. (Specify whether)

In this community. (Specify whether)

years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Kingsburg

(c) City or town Edwards

(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. 0

3. (a) PRINT FULL NAME Thomas Jefferson Phillips

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex male 5. Color or race White

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

6. (b) Name of husband or wife

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

7. Birth date of deceased. Oct 1 1861

(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>81</u>	<u>4</u>	<u>26</u>	hr. min.

9. Birthplace Kingsville Mo.

(City, town, or county) (State or foreign country)

10. Usual occupation Minister

11. Industry or business

MOTHER FATHER

12. Name Lemuel Phillips

13. Birthplace Unknown

(City, town, or county) (State or foreign country)

14. Maiden name Sarah Jane Howard

15. Birthplace Unknown

(City, town, or county) (State or foreign country)

16. (a) Informant Perkins Cannon

(b) Address Edwards Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof FEB 28 43

(Month) (Day) (Year)

(c) Place: burial or cremation Edwards Mo.

18. (a) Signature of funeral director W. W. Roddy

(b) Address Edwards Mo.

19. (a) Mar 20 1948 (Date received local registrar) (b) H. B. Dillman (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb day 27

year 1943, hour _____ minutes _____ M.

21. I hereby certify that I attended the deceased from 12-12-

42 to 2-27- 43

that I last saw him alive on 3-20- 43

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

Immediate cause of death Terminal Pneumonia

Due to Cerebral Neovascular

Due to alcohol insufficiency and hypoxia

Other conditions (Include pregnancy within 3 months of death)

Duration 4 yrs

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) Means of injury

23. Signature H. B. Dillman (M. D. brother)

Address Edwards Mo. Date signed 3-1-43

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 W H Bradley

Licensed Embalmer No. 3966

P. O. Address Edsburg, Md

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. 14747
Registrar's No. 8

Registration District No. 181

Primary Registration District No. 4293

1. PLACE OF DEATH:

(a) County Lincoln
(b) City or town Ealsberry
(c) Name of hospital or institution:
(If outside city or town limits, write "RURAL" and name of township)
(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 Thomas G. Phillips

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 w

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

7. Birth date of deceased Oct. 1 - 1866
(Month) (Day) (Year)

8. AGE: Years 81 Months 4 Days _____ If less than one day _____ min.

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

10. Usual occupation _____

11. Industry of 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 _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

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

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

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Lincoln
(c) City or town Ealsberry
(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 Feb. day 2
year 1943 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ 19____;
that I last saw him _____ live on _____ 19____;
and that death occurred on the date and hour stated above.
Immediate cause of death _____

Chromosomal Pneumonia
Due to Cerebral hemorrhage 52%
Arteriosclerosis 48%

Due to Hypertension 14%
Other conditions Chronic glomerulonephritis
(Include pregnancy list in 3 months of death)

Major findings of operations Hypertensive congestive heart failure
Of autopsy Chromosomal pneumonia
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) Method of injury _____

23. Signature D. J. Stebbins (M. D. or other) _____

Address Ealsberry, Mo. Date signed _____

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

SUPPLEMENTARY

MOTHER FATHER

S-14747