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5-17-39  
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DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 28656

FILED SEP 15 1944

Registrar's No. 114

Registration District No. 318

Primary Registration District No. 305-8

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

1. PLACE OF DEATH:

(a) County St. Charles

(b) City or town St. Charles  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: St. Joseph Hospital  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 2 weeks  
(Specify whether)

In this community \_\_\_\_\_  
years, months or days

3. (a) PRINT FULL NAME Edward 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 Married

6. (b) Name of husband or wife Anna Phillips 6. (c) Age of husband or wife if alive 75 years

7. Birth date of deceased December 16 1862  
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>81</u>	<u>7</u>	<u>22</u>	hr. _____ min.

9. Birthplace St. Charles Co. Mo.  
(City, town, or county) (State or foreign country)

10. Usual occupation Farmer

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

MOTHER FATHER { 12. Name John Phillips

13. Birthplace Germany 4  
(City, town, or county) (State or foreign country)

14. Maiden name Fehr

15. Birthplace St. Charles Co. Mo. 0  
(City, town, or county) (State or foreign country)

16. (a) Informant Clem Phillips

(b) Address St. Charles Mo.

17. (a) Burial (b) Date thereof Aug. 11 1944  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Cottleville Mo.

18. (a) Signature of funeral director E.A. Keithly

(b) Address O'Fallon Mo.

19. (a) 8/11/44 (b) Ernest E. Paul  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED: 92

(a) State Missouri (b) County St. Charles

(c) City or town St. Peters Rural  
(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 Aug. day 8  
year 1944 hour 9 minute A M.

21. I hereby certify that I attended the deceased from July 1, 1944, to Aug. 8, 1944.  
that I last saw him live on Aug 8, 1944  
and that death occurred on the date and hour stated above.

Immediate cause of death Uræmia 3 day  
Duration

Due to Chronic Nephritis ?

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

Other conditions Corony Sclerosis ?  
(Include pregnancy within 3 months of death)

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

Of autopsy 131 P

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 [Signature] (M. D. or other) \_\_\_\_\_  
Address [Address] Date signed 8-10-44

1340 (Licensed Embalmer's Statement on Reverse Side)

RECEIVED

District Health Officer No.

District File Number

Date Filed

9-14-44

**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

*E. K. Smith*

Licensed Embalmer No.

874

P. O. Address

*O'Fallon Mo.*

**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.**