

FILED JAN 10 1945  
335  
Registration District No. **335**

Primary Registration District No. **6118**

Registrar's No. \_\_\_\_\_

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

1. PLACE OF DEATH:

(a) County **Scott**  
(b) City or town **Oran, Mo.**  
(c) Name of hospital or institution: **Rural**  
(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 **Lenda Jean Phillips**

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex **F** 5. Color or race **W** 6. (a) Single, widowed, married, divorced **infant**  
6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if \_\_\_\_\_  
years  
7. Birth date of deceased **May 13 1944**  
(Month) (Day) (Year)

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

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

10. Usual occupation **infant**

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

12. Name **Merion Phillips**

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

14. Maiden name **Madell Boley**

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

16. (a) Informant **Daisy Boley**

(b) Address **Oran Mo.**

17. (a) \_\_\_\_\_ (b) Date thereof **10 Sep - 22 1944**  
(Month) (Day) (Year)

(c) Place: burial or cremation **Parsons, Mo.**

18. (a) Signature of funeral director **[Signature]**

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

19. (a) **Jan 3 - 1945** (Registered Signature) **[Signature]**

(Date received local registrar)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo** (b) County **Scott**  
(c) City or town **Oran**  
(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 **Dec** day **18** - 19**44**  
year **1944** hour **10** minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from **Dec 15 - 1944**  
19**44**, to **Dec 18** 19**44**  
that I last saw h. **aw** alive on **Dec 17** 19**44**  
and that death occurred on the date and hour stated above.

Immediate cause of death: **Intestinal influenza**  
Due to \_\_\_\_\_  
Due to **33**  
Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

Duration

**3 or 4 days**

PHYSICIAN

Underline the cause to which death should be charged statistically.

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 \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)

(c) 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 \_\_\_\_\_

23. Signature **W. D. Savaugh** (M. D. or other) **MD**

Address **Allenville** Date signed **Dec 18 1944**

RECEIVED

District Health Office No. 2

District File Number 145-4

Date Filed 1-6-45

STATEMENT BY LICENSED EMBALMER

I hereby state 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.