

S. No. 2
M-2-43
5-17-39
X35697

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED FEB 13, 1945

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 1574

Registration District No. 1

Primary Registration District No. 3000

Registrar's No. 21

1. PLACE OF DEATH:
(a) County Adair
(b) City or town Lebanon
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Laughlin Hosp
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution. 0 (Specify whether
In this community _____ years, months or days)

3. (a) PRINT FULL NAME JOSEPHINE Philbert
3. (b) If veteran _____ name war _____
3. (c) Social Security No. _____

4. Sex F 1
5. Color or race W
6. (a) Single, widowed, married, divorced 2
6. (b) Name of husband or wife Cery Philbert
6. (c) Age of husband or wife if alive 63 years
7. Birth date of deceased: Oct (Month) _____ (Day) _____ (Year)

8. AGE: Years 50 Months _____ Days _____ If less than one day _____ hr. _____ min.

9. Birthplace Texas (City, town or county) S 2 1 (State or foreign country)

10. Usual occupation house wife

11. Industry or business
12. Name J. O. Keir
13. Birthplace Fort Knox (City, town, or county) 9 (State or foreign country)
14. Maiden name Fort Knox
15. Birthplace _____ (City, town or county) _____ (State or foreign country)

16. (a) Informant Dr. J. D. St. Louis
(b) Address Wymore Neb.

17. (a) Reburial (b) Date thereof 1-30-45 (Month) (Day) (Year)
(c) Place: burial or cremation Blue Springs Neb

18. (a) Signature of funeral director Sumner Howell
(b) Address Lebanon Mo

19. (a) 1-30-45 (b) Mrs. J. S. Wayman (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Wymore (b) County Nebraska
(c) City or town _____ (If outside city or town limits, write "RURAL") 999
(d) Street No. _____ (If rural, give location) 35
(e) Citizen of foreign country? _____ (Yes or No) 0
If yes, name country _____ 2

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 30
year 1945 hour 12 minute 30 P. M.
21. I hereby certify that I attended the deceased from Jan 24, 1945 to Jan 30, 1945
that I last saw her alive on Jan 30, 1945
and that death occurred on the date and hour stated above.

Immediate cause of death: metastatic carcinoma
Due to: Primary in bowel

Due to _____
Other conditions (include pregnancy within 3 months of death) _____

Major findings: Of operations 4/6
Of autopsy _____

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 Earl Laughlin (M. D. or other) Do.
Address Lebanon Mo Date signed 1/30/45

(Licensed Embalmer's Statement on Reverse Side)

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

MOTHER FATHER

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

1049

SEP 25 1945

MAR 2 1945

FEB 11 1945

FEB 11 1945

RECEIVED

Health Officer No. 10

State File Number 2-45-812

Date Filed FEB 11 1945

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. C. Summers

Licensed Embalmer No. 2159

P. O. Address Kirkville, 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.