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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED MAY 12 1945
Registration District No. **1818**

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

11658
State File No.
Registrar's No. **3991**

Primary Registration District No. **1003**

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

1. PLACE OF DEATH:
(a) County
(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Children's Hospital
(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 Missouri (b) County COO
(c) City or town St. Louis
(If outside city or town limits, write "RURAL")
(d) Street No. 2735 Delmar
(If rural, give location)
(e) Citizen of foreign country? 0 (Yes or No)
If yes, name country.....

3. (a) PRINT FULL NAME Betty Jean Phillips
3. (b) If veteran, name war.....
3. (c) Social Security No.....

4. Sex Female 5. Color or race Negro
6. (a) Single, widowed, married, Child
Divorced
6. (c) Age of husband or wife if
alive..... years
7. Birth date of deceased Feb. 3 1944
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
3 3 0 hr. min.

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

10. Usual occupation.....

11. Industry or business.....

MOTHER FATHER { 12. Name Ceaser Phillips
13. Birthplace Brookfield Miss
(City, town, or county) (State or foreign country)
14. Maiden name Betty Lee Mackans
15. Birthplace Brookfield Miss
(City, town, or county) (State or foreign country)

16. (a) Informant Ceaser Phillips
(b) Address 2735 Delmar Ave

17. (a) Burial (b) Date thereof May 5, 1945
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Greenwood Cem.
Dement & Son

18. (a) Signature of funeral director.....
(b) Address 261 Cole St.

19. (a) MAY 4 1945 (b) J. F. Budeck
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 3
year 45 hour 4 minute 45 P.M.
21. I hereby certify that I attended the deceased from April 19
1945, to May 3 1945;
that I last saw h. E.R. alive on May - 3 1945;
and that death occurred on the date and hour stated above.

Immediate cause of death Pituitary adenoma with metastases to liver, ovaries, pancreas, lungs, scap, dura
Due to.....

Due to.....
Other conditions.....
(Include pregnancy within 3 months of death)

Major findings:
Of operations.....
Of autopsy See above
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 0

23. Signature R. J. Blanton, M.D. (M. D. or other)
Address Children's (Doctor M.D.)
Date signed 5-3-45

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. Claude Gordon

Licensed Embalmer No. 13489

P. O. Address 4575 Aldine

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.