

**FILED** AUG 18 1945

Registration District No. **106**

Primary Registration District No. **2001**

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

1. PLACE OF DEATH:

(a) County **JASPER**

(b) City or town **JOPLIN**  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: **1116 Jackson**  
(If not in hospital or institution, write street number or location)

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

In this community **LIFETIME** years, months or days

3. (a) PRINT FULL NAME **MINNIE B. 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 \_\_\_\_\_

6. (b) Name of husband or wife \_\_\_\_\_

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

7. Birth date of deceased: **Oct 2 1893**  
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<b>52</b>	<b>9</b>	<b>23</b>	hr. _____ min.

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

10. Usual occupation **operator and**

11. Industry or business **owner Grocery**

12. Name **Wm John Blaukauship**

13. Birthplace **Tenn**  
(City, town, or county) (State or foreign country)

14. Maiden name **Eda McHale**

15. Birthplace **Tenn**  
(City, town, or county) (State or foreign country)

16. (a) Informant **Blaukauship**

(b) Address **Joplin Mo**

17. (a) **burial** (b) Date thereof **7-30-45**  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Forest Park**

18. (a) Signature of funeral director **Thornhill-Dillon**

(b) Address **305 WEST FOURTH**

19. (a) **7-30-45** (b) **Arthur H. H. H. H.**  
(Date received local registrar) (Registrar's Signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **MISSOURI** (b) County **JASPER**

(c) City or town **Joplin**  
(If outside city or town limits, write "RURAL")

(d) Street No. **1116 Jackson Ave**  
(If rural, give location)

(e) Citizen of foreign country? **No** (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **July** day **25**  
year **1945** hour **6** minutes **30 a. M.**

21. I hereby certify that I attended the deceased from **7-25 1945** to **7-25 1945**  
that I last saw her alive on **7-25-45** and that death occurred on the date and hour stated above.

Immediate cause of death **Coronary Occlusion**  
Duration **1 hr**

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

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

Other conditions (Includes pregnancy within 3 months of death) \_\_\_\_\_

Major findings: **gastro**

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 \_\_\_\_\_

(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 work) (Means of injury)

23. Signature of physician **DR Kuchn** (M. D. or other) \_\_\_\_\_

Address **Joplin Mo** Date signed **7-30-45**

45-7-644

MAY 11 1948

JUN 18 1946

OCT - 8 - 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 CEILA THORNTON

Licensed Embalmer No. 3590

P. O. Address Top 177 No 1

**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.**