

U.S. No. 2
FORM-5-43
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I-X36671

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED DEC 24 1946
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THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **40250**
Registrar's No. **996**

Registration District No. _____ Primary Registration District No. **2000**

1. PLACE OF DEATH:
(a) County **GREENE**
(b) City or town **Springfield**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
533 E. Elm
(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 **Greene** **39**
(c) City or town **Springfield**
(If outside city or town limits, write "RURAL") **5**
(d) Street No. **533 E. Elm**
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME **MAXY W. PHILLIPS**
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____
4. Sex **Male** 0 5. Color or race **white** 6. (a) Single, widowed, married, divorced **married** /
6. (b) Name of husband or wife **Mae Reese Phillips** 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased **August 15, 1894**
(Month) (Day) (Year)

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **December** day **12**
year **1946** hour **2:30 A.M.** minute _____ M.
21. I hereby certify that I attended the deceased from **November 9, 1946** to **December 11, 1946**;
that I last saw him alive on **December 11, 1946**;
and that death occurred on the date and hour stated above.
Immediate cause of death **Respiratory failure due to metastasis to lungs.** Duration _____
Due to **Metastasis to lungs**

8. AGE: Years Months Days If less than one day
52 **3** **27** hr. _____ min. _____
9. Birthplace **Polo, Missouri** 0
(City, town, or county) (State or foreign country)
10. Usual occupation **Salesman**

Other conditions **Carcinoma naso-pharynx**
(Include pregnancy within 3 months of death)
Due to _____
Major findings:
Of operations _____
Of autopsy _____

11. Industry or business _____
12. Name **Wm. E. Phillips** /
13. Birthplace **Kentucky** /
(City, town, or county) (State or foreign country)
14. Maiden name **Sarah Alice Carr**
15. Birthplace **Myrabile, Missouri** 0
(City, town, or county) (State or foreign country)
16. (a) Informant **Mrs. Mae Reese Phillips**
(b) Address **533 E. Elm**
17. (c) **Burial** (Burial, cremation, or removal) (b) Date thereof **12/14/1946**
(Month) (Day) (Year)
(c) Place: burial or cremation **Hazelwood Cemetery**
18. (a) Signature of funeral director **ALMA LOHMEYER FUNERAL HOME**
Springfield, Missouri
(b) Address _____
19. (a) **12-14-46** (b) **W. H. Handley MD**
(Date received local registrar) (Registrar's signature)

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) (c) Means of injury **12** ✓
23. Signature **John J. Sullivan** (M. D. or other) _____
Address **2nd St. Bell** Date signed **12-13-46**

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

MOTHER, FATHER

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FORM 20 1947

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..... *C. A. Roof*
Licensed Embalmer No. 3044
P. O. Address..... Springfield, Missouri

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.