

FILED SEP 17 1947

Registration District No. _____

Primary Registration District No. 3160

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Adair

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

(c) Name of hospital or institution: Shin-Smith Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 16 days
(Specify whether)

In this community all life
(years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Schuyler

(c) City or town Downing
(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 _____

3. (a) PRINT FULL NAME Callie Dona 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 w

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased Feb. 24 1867
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day

80 5 26 hr. min.

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

10. Usual occupation housewife

11. Industry or business _____

12. Name Robert Henry Masie

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

14. Maiden name Margaret Green

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

16. (a) Informant Mrs. Beacie Benraft

(b) Address Memphis, Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-22-47
(Month) (Day) (Year)

(c) Place: burial or cremation Pleasant Grove

18. (a) Signature of funeral director Lloyd Moore

(b) Address Downing, Mo.

19. (a) Aug 30 1947 (Date received local registrar) (b) Mrs. A. J. Drake (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 20
year 1947 hour 5 minute P. M.

21. I hereby certify that I attended the deceased from August 4 1947 to August 19 1947
that I last saw her alive on August 20 1947
and that death occurred on the date and hour stated above.

Immediate cause of death Pulmonary embolism
trauma hip

Due to _____

Due to _____

Other conditions: _____
(Include pregnancy within 3 months of death)

Major findings: _____

Of operations _____

Of autopsy _____

18618

ADDITIONAL PHYSICIAN SUPPLEMENTARY INFORMATION REQUESTED

Underline 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) accident 98

(b) Date of occurrence Aug 4 1947

(c) Where did injury occur? Downing Schuyler Mo
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?
none

While at work? _____ (Specify type of place)

(e) Means of injury _____

23. Signature A. J. Drake (M. D. or other) 0
Address Berkeley Mo Date signed 8-20-47

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

RECEIVED
District Health Officer No. 1
District File Number 9-47-12
Date Filed SEP 11 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 me

....., Registered Apprentice No.
working under my personal supervision.

Signed Lloyd Moore

Licensed Embalmer No. 3151

P. O. Address Downing 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.

No. 22
M. 341
11-43880

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. act

Registration District No. 1

Primary Registration District No. 3000

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Adair
(b) City or town Kuberville
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(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

Callie D. 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 and

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____

7. Birth date of deceased Feb. 24 (Month) (Day) (Year)

8. AGE: Years 80 Months _____ Days _____ If less than one day _____ hr. _____ min.

9. Birthplace _____ (City, town, or county) (State or foreign country) MO

10. Usual occupation _____

11. Industry or business _____

12. Name _____

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

14. Maiden name _____

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

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof _____ (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) _____ (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____
(c) City or town _____ (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 _____ year 1947 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ to _____ 19____
that I last saw him _____ and that death occurred on the date and hour stated above.
Immediate cause of death _____

Due to _____

Due to _____

Other conditions _____ (Include pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy _____

186 A
14

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) accident

(b) Date of occurrence Aug 4 1947

(c) Where did injury occur? Chrysler MO (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 fall

23. Signature _____ (M. D. or other) _____ Date signed _____

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

MOTHER FATHER

SUPPLEMENTARY

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

S 30214