

No. 2  
-1/47  
5-17-39

36152  
10226

FEDERAL SECURITY AGENCY

MISSOURI DIVISION OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. ....

Registrar's No. ....

FILED NOV 14 1947

318

Primary Registration District No. ....

1003

Registration District No. ....

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: FIRMIN DESLOGE, O  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution.....  
In this community.....  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State..... MO. (b) County..... 600  
(c) City or town..... ST. LOUIS 17  
(If outside city or town limits, write "RURAL")  
(d) Street No. 3324 CAROLINE ST. ?  
18  
(If rural, give location)  
(e) (Citizen of foreign country?..... (Yes or No)  
If yes, name country.....

3. (a) PRINT FULL NAME..... JOHN T. PHILLIPS  
3. (b) If veteran, name war.....  
3. (c) Social Security No. ....

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month November day 3  
year 1947 hour..... minute 05 p. M.

4. Sex..... MO 5. Color or race..... W  
6. (a) Single, widowed, married, divorced..... MARRIED  
6. (b) Name of husband or wife..... OLIVE PHILLIPS  
6. (c) Age of husband or wife if alive..... years  
7. Birth date of deceased..... SEPTEMBER 1 1884  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from  
Oct - 6 1947 to Nov - 3 1947  
that I last saw him alive on Nov - 2 1947  
and that death occurred on the date and hour stated above.

8. AGE: Years Months Days If less than one day  
63 2 2 hr. min.

Immediate cause of death.....  
Conhosis of Liver 2 minutes  
Hypostatic Pneumonia 2 days  
Due to.....

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

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

10. Usual occupation..... UPHOLSTERING

Major findings:  
Of operations.....

11. Industry or business..... KARMEN, CO

12. Name..... ROBERT T. PHILLIPS

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

14. Maiden name..... LOUISA SHARP

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

16. (a) Informant..... Mrs Olive Phillips  
(b) Address..... 3324 Caroline St

17. (a) BURIAL  
(Burial, cremation, or removal) (b) Date thereof..... NOV 6 - 47  
(Month) (Day) (Year)  
(c) Place: burial or cremation..... VALHALLA CEM.

18. (a) Signature of funeral director..... E. J. Schuur  
(b) Address..... 3125 Lafayette Av

Of autopsy..... Confirmed diagnosis given above

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?..... (Specify type of place)

While at work?..... (e) Means of injury..... WD

23. Signature..... GO Brown (M. D. or other) WD  
Address..... 1325 S Grand Blvd. Date signed..... 11/4/47

PHYSICIAN  
Underline the cause of which death should be charged statistically.

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

MOTHER FATHER

**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.....

*Joseph B. Kollmer*

Licensed Embalmer No. ....

*4014*

P. O. Address.....

*3125 Lafayette*

**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.

Registration District No. 318

Primary Registration District No. 1003

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:  
  
(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

John J. Phillips

3. (b) If veteran name war..... 3. (c) Social Security No.....

4. Sex m 5. Color or race w 6. (a) Single, widowed, married, divorced m

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

7. Birth date of deceased sex  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day hr. min. 62 no

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

10. Usual occupation

11. Industry or business

MOTHER FATHER { 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) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)

(c) Place: burial or cremation.....

18. (a) Signature of funeral director.....

(b) Address

19. (a) 11-5-47 (b) J. F. Bradeck  
(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 Nov 3  
year 1947 hour..... minute..... M.

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

Duration

Due to.....  
Due to.....

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

Major findings:  
Of operations.....

Of autopsy.....

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.....

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

SUPPLEMENTARY

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

NOV 19 1947

S-36152