

S. No. 2
I-1/47
5.17.39

33482

FEDERAL BUREAU OF INVESTIGATION
National Office of Vital Statistics
MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. _____
Registrar's No. 144

Registration District No. 187
Primary Registration District No. 3040

1. PLACE OF DEATH:
(a) County LIVINGSTON
(b) City or town Chillicothe
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 409 E. Clay
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 1 year (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County LIVINGSTON
(c) City or town Chula
(If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Matilda Phillips
3. (b) If veteran, - name war _____
3. (c) Social Security No. _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Oct day 30
year 1948 hour 7 minute 15 P. M.
21. I hereby certify that I attended the deceased from June 1
1948, to Oct 30 1948
that I last saw her alive on Oct 30 1948
and that death occurred on the date and hour stated above.

4. Sex Female 5. Color or race white
6. (a) Single, widowed, married, divorced. Single
6. (b) Name of husband or wife _____
6. (c) Age of husband or wife if alive 5 years (Day) (Year)

Immediate cause of death Chronic myocarditis
Duration 4 yrs

8. AGE: Years Months Days If less than one day
89 11 25 hr. _____ min.

Due to _____
Due to _____

9. Birthplace LIVINGSTON Co, Missouri
(City, town, or county) (State or foreign country)

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

10. Usual occupation Housewife

PHYSICIAN
Major findings: 9/15/48
Of operations _____
Of autopsy _____

MOTHER FATHER

11. Industry or business _____
12. Name William Dennis Phillips
13. Birthplace Not known Ohio
(City, town, or county) (State or foreign country)
14. Maiden name Sarah Goethel
15. Birthplace Not known Ohio
(City, town, or county) (State or foreign country)

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 _____
23. Signature J. Callan (M. D. or other) _____
Address Chillicothe Mo Date signed Oct 27-48

16. (a) Informant James Steig
(b) Address 607 Wilson Chillicothe Mo
17. (a) Burial (b) Date thereof 11-1-1948
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Wallace-chula
18. (a) Signature of funeral director E. J. Robertson, Funeral Home
(b) Address Chula
19. (a) Oct-31-48 (b) Frances B. Hurd
(Date received local registrar) (Registrar's signature)

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

59
1
2

DISTRICT HEALTH OFFICE
Cameron, Mo.

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 *John M Robertson*

Licensed Embalmer No. *4388*

P. O. Address *Laredo 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.