

FILED NOV 21 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **36732**

BIRTH NO. _____ REG. DIST. NO. 86 PRIMARY REG. DIST. NO. 5328 Registrar's No. _____

1. PLACE OF DEATH a. COUNTY <u>Crawford</u>		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission.) a. STATE <u>Missouri</u> b. COUNTY <u>Randolph</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Heartsburg, Liberty Twp</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Heartsburg, Mo.</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>P.P.#</u>		d. STREET ADDRESS (If rural, give location) <u>P.P.# 1</u>	
3. NAME OF DECEASED (Type or Print) a. (First) <u>John</u> b. (Middle) <u>Franklin</u> c. (Last) <u>Phillips</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>11-12-1949</u>	
5. SEX <u>M.O.</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>3-16-1878</u>
9. AGE (In years last birthday) <u>71</u>		10. a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>	10. b. KIND OF BUSINESS OR INDUSTRY <u>General Contractor</u>
11. BIRTHPLACE (State or foreign country) <u>Springfield Mo</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13a. FATHER'S NAME <u>John Franklin Phillips</u>		13b. MOTHER'S MAIDEN NAME <u>Mamie Campbell</u>	
14. NAME OF HUSBAND OR WIFE <u>MAMIE Phillips</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) _____	
16. SOCIAL SECURITY NO. <u>489-16-8382</u>		17. INFORMANT'S SIGNATURE OR NAME <u>Mrs. Mamie Phillips</u> ADDRESS <u>Heartsburg, Mo.</u>	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Coronary thrombosis</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Arteriosclerosis</u> <u>Heart Disease</u> DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>4 201</u>	
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT SUICIDE HOMICIDE (Specify) _____	
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) _____	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR? _____			
22. I hereby certify that I attended the deceased from <u>Sept</u> , 1949, to <u>Nov 12</u> , 1949, that I last saw the deceased alive on <u>Nov 5</u> , 1949, and that death occurred at _____ m., from the causes and on the date stated above.			
23a. SIGNATURE (Degree or title) <u>John P. DeLoore, M.D.</u>		23b. ADDRESS <u>Sullivan, Mo.</u>	
23c. DATE SIGNED <u>11/13/49</u>		24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>	
24b. DATE <u>11-15-1949</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Cross Road Cem</u>	
24d. LOCATION (City, town, or county) (State) <u>Heartsburg, Mo. P.P.# 1</u>		25. FURNERAL DIRECTOR'S SIGNATURE <u>Paul C. Shank</u> ADDRESS <u>Cuba, Mo.</u>	
DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE <u>11-15-1949</u> <u>M. C. Davis</u>		372	

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

RECEIVED

11/18/49

District Health Officer No. 5,

District File Number 114 9712

Date Filed 11/18/49

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 _____

working under my personal supervision.

Student
Student Embalmer

Student Embalmer No. _____

Signed _____

Licensed Embalmer No. 3472

P.-O. Address Cuba, Fla.

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.