

FILED SEP 15 1950

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 29137

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 331 PRIMARY REG. DIST. NO. 6113 Registrar's No. 26

1. PLACE OF DEATH a. COUNTY <u>Scott</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Unknown</u> b. COUNTY _____	
b. CITY OR TOWN <u>Benton Birch Northland</u>	c. LENGTH OF STAY (in this place) <u>6 yr</u>	c. CITY OR TOWN <u>Unknown 10000</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>County Farm</u>		d. STREET ADDRESS (If rural, give location) <u>0</u>	

3. NAME OF DECEASED a. (First) <u>Henry</u> b. (Middle) <u>NMN</u> c. (Last) <u>Phehps</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>Aug 29 1950</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Never Married</u>	8. DATE OF BIRTH <u>Unknown 1871</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <input checked="" type="checkbox"/>	11. BIRTHPLACE (State or foreign country) <u>Unknown 9</u>
13a. FATHER'S NAME <u>Unknown</u>		13b. MOTHER'S MAIDEN NAME <u>Unknown</u>	14. NAME OF HUSBAND OR WIFE <u>None</u>
12. CITIZEN OF WHAT COUNTRY? <u>US</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>	

16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT'S SIGNATURE OR NAME <u>Mrs Ada Belle Dickerson</u> ADDRESS <u>Benton Mo</u>	
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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, asthma, etc. It means the disease, injury, or complication which caused death.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Ch Myocarditis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 years</u>
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Senility age 79</u> DUE TO (c) _____		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		<u>4222</u>	

19a. DATE OF OPERATION _____	19b. MAJOR FINDINGS OF OPERATION _____	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. ACCIDENT SUICIDE HOMICIDE (Specify) <u>10</u>	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? _____
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22. I hereby certify that I attended the deceased from 1948 to 1950, that I last saw the deceased alive on 9/26, 1950 and that death occurred at 4 P m., from the causes and on the date stated above.

23a. SIGNATURE <u>W. D. Pruitt, M.D.</u> (Degree or title)	23b. ADDRESS <u>Chaffee</u>	23c. DATE SIGNED <u>9/15/50</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>0</u>	24b. DATE _____	24c. NAME OF CEMETERY OR CREMATORY _____	24d. LOCATION (City, town, or county) (State) _____
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DATE REC'D BY LOCAL REG. <u>9-7-50</u>	REGISTRAR'S SIGNATURE <u>McLaddie Harvie</u> 395	25. FUNERAL DIRECTOR'S SIGNATURE <u>B. S. P. ...</u> ADDRESS <u>Chaffee</u>
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RECEIVED SEP 8 1950  
SCOTT COUNTY HEALTH C  
CO. FILE NO. 950 -

**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 <sup>not</sup> \_\_\_\_\_

Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student .....  
Student Embalmer

Signed \_\_\_\_\_

*Mamie B. Dimplinghoff*

Licensed Embalmer No. 3242

P. O. Address Chaffee Mo.

Note: The above **MUST BE SIGNED BY THE LICENSED EMBALMER** in his **OWN HANDWRITING**. (Failure to complete the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.