

FILED AUG 18 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **27611**
3633

BIRTH NO. _____ REG. DIST. NO. 149 PRIMARY REG. DIST. NO. 1002 Registrar's No. _____

1. PLACE OF DEATH a. COUNTY Jackson		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Jackson	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Kansas City		c. LENGTH OF STAY (in this place) 27 yrs.	d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION 1005 Bales		f. STREET ADDRESS (If rural, give location) 1005 Bales	

3. NAME OF DECEASED (Type or Print) a. (First) NELIA	b. (Middle) ALICE	c. (Last) PHILPOTT	4. DATE OF DEATH (Month) (Day) (Year) 7 23 54
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) widowed 2	8. DATE OF BIRTH 10-15-67
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At home		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) 86
		11. BIRTHPLACE (City and State or Foreign Country) Holden, Missouri 0	12. CITIZEN OF WHAT COUNTRY? USA

13a. FATHER'S NAME Bert L. McFerrin	13b. MOTHER'S MAIDEN NAME Nancy Wall	14. NAME OF HUSBAND OR WIFE Joe Thomas Philpott
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO	16. SOCIAL SECURITY NO. none	17. INFORMANT'S SIGNATURE OR NAME Miss Josephine Philpott	ADDRESS 1005 Bales, KC, Mo.
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Congestive Heart Failure		DUPLICATE		
*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		4200
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION None		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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) (Min.)	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 July 20, 1954, to July 23, 1954, that I last saw the deceased alive on July 20, 1954, and that death occurred at 11:15A.m., from the causes and on the date stated above.

23a. SIGNATURE Paul A. G. Johnson MD	23b. ADDRESS 5111 Ludlow Ave. K.C. Mo.	23c. DATE SIGNED 7/24/54
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24a. BURIAL, CREMATION, REMOVAL (Specify) Rem. & Burial	24b. DATE 7-25-54	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State) Blairstown, Missouri
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DATE REC'D BY LOCAL REG. 7-24-54	REGISTRAR'S SIGNATURE Staldine Smith	25. FUNERAL DIRECTOR'S SIGNATURE Mellody-McGilley-Eylar	ADDRESS Kansas City, Mo.
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(Licensed Embalmer's Statement on Reverse Side)

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

5111 Independence

Be 7943

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 Student Embalmer No..... working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed *Arthur E. Hook*.....

Licensed Embalmer No. *49*.....

P. O. Address *RCM*.....

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.