

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

12823

STATE FILE NUMBER

FILED APR 22 1957

Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 365

Health,
Welfare
Public
Service

300
1-56

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

| | | | | | | | |
|---|----------------------------------|---|---|---|--|---|--|
| 1. PLACE OF DEATH a. COUNTY Greene | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY VERNON | | | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Springfield | | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | c. CITY OR TOWN Walker | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Burge Hospital | | | Length of stay in 1b | d. STREET ADDRESS (If outside, give location) None | | Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First MYRTLE Middle V. Last PHILLIPS | | | | 4. DATE OF DEATH Month April Day 13 Year 1957 | | | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 16 May 1887 | 9. AGE (In years last birthday) 69 | IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY Home | 11. BIRTHPLACE (City and state or country) Indiana | | 12. CITIZEN OF WHAT COUNTRY? USA | | |
| 13. FATHER'S NAME Dickey | | | 14. MOTHER'S MAIDEN NAME Unknown | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. Yes | 17. INFORMANT Hospital Records Address | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial infarction with mixture of myocardial wall. Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | INTERVAL BETWEEN ONSET AND DEATH 5 hours | |
| 20a. ACCIDENT <input type="checkbox"/> | SUICIDE <input type="checkbox"/> | HOMICIDE <input type="checkbox"/> | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 4201 | | | | |
| 20c. TIME OF INJURY Hour Month, Day, Year a. m. p. m. | | | | | | | |
| 20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 20f. CITY, TOWN, OR LOCATION | | COUNTY | STATE | |
| 21. I attended the deceased from March 8, 1957 to April 13, '57 and last saw her alive on April 12, 1957 . Death occurred at 4:20 A.M. m on the date stated above; and to the best of my knowledge, from the causes stated. | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 22a. SIGNATURE (Degree or title) K. Wendell Stewart M.D. | | | | 22b. ADDRESS 214 Professional Bldg. Springfield 4, Mo | | 22c. DATE SIGNED April 16, 1957 | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE 4-16-57 | 23c. NAME OF CEMETERY OR CREMATORY Schell City Cemetery | | 23d. LOCATION (City, town, or county) (State) Schell City, Missouri | | | |
| 24. FUNERAL DIRECTOR Jaw Klingsner & Co. ADDRESS Spfgd. Mo. | | | 25. DATE RECD. BY LOCAL REG. 4-16-57 | | 26. REGISTRAR'S SIGNATURE Edith Williams | | |

Removal-Burial

(Licensed Embalmer's Statement on Reverse Side)

APR 22 1957

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..... *Max Rhodes*

Licensed Embalmer No. 407

P. O. Address..... *Springfield*

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.