

FILED OCT 7 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 31078
Registrar's No. 441

BIRTH NO. _____ REG. DIST. NO. 53 PRIMARY REG. DIST. NO. 3010

1. PLACE OF DEATH a. COUNTY CAPE GIRARDEAU		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE MISSOURI b. COUNTY SCOTT	
b. CITY (If outside corporate limits, write RURAL and give township) CAPE GIRARDEAU		c. CITY (If outside corporate limits, write RURAL and give township) ORAN	
c. LENGTH OF STAY (In this place) 2 WEEKS		d. STREET ADDRESS (If rural, give location) ORAN	
d. FULL NAME OF HOSPITAL OR INSTITUTION ST. FRANCIS HOSPITAL			

3. NAME OF DECEASED (Type or Print) a. (First) LeOra b. (Middle) c. (Last) Phillips			4. DATE OF DEATH (Month) (Day) (Year) September 19 1957		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married	8. DATE OF BIRTH May 15 1898	9. AGE (In years last birthday) 59	IF UNDER 1 YEAR Months Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk		10b. KIND OF BUSINESS OR INDUSTRY Grocery Store	11. BIRTHPLACE (State or foreign country) Hunt Town Arkansas		12. CITIZEN OF WHAT COUNTRY? U. S. A.

13a. FATHER'S NAME James H. Pyron	13b. MOTHER'S MAIDEN NAME Nora Stewart	14. NAME OF HUSBAND OR WIFE Ben Phillips
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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. 493-30-6747	17. INFORMANT'S SIGNATURE OR NAME Ben Phillips	ADDRESS Oran, Mo.
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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, asthenia, etc. It means the disease, injury, or complication which caused death.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a) adenoCa thyroid		INTERVAL BETWEEN ONSET AND DEATH 4 mos
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		
	II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. 194X		

19a. DATE OF OPERATION 7-29-57	19b. MAJOR FINDINGS OF OPERATION enlarged Cervical thyroid Extension to trachea	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) m.	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 **7-22, 1957**, to **9-19, 1957**, that I last saw the deceased alive on **7-19, 1957**, and that death occurred at **12:40P** m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Frank Hall M.D.	23b. ADDRESS Cape Girardeau Mo	23c. DATE SIGNED 9-27-57
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE Sept. 22 1957	24c. NAME OF CEMETERY OR CREMATORY Forest Hill Memorial	24d. LOCATION (City, town, or county) (State) Morley Mo.
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DATE REC'D BY LOCAL REG. 9-30-57	REGISTRAR'S SIGNATURE C. C. Summers	25. FUNERAL DIRECTOR'S SIGNATURE Carl Smith	ADDRESS Oran, Mo.
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

Handwritten notes on the left margin.

Handwritten number 74 in the bottom left corner.

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 Embalmer No.

Signed Earl J. Smith

Signed.....
Student Embalmer

Licensed Embalmer No. 3676

P. O. Address Oron, 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.