

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-023619

STATE FILE NUMBER

6204

FILED JUN 27 1958

Registration District No.

318

Primary Registration District No.

1003

Registrar's No.

5. 300

1-57

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

| | | | | | | | | |
|--|----------------------------------|---|--|---|--|--|--|-------------------------------------|
| 1. PLACE OF DEATH a. COUNTY | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY | | | | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis | | | Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/> | c. CITY OR TOWN St. Louis | | Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/> | | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Homer G. Phillips | | | Length of stay in lb 1 wk | d. STREET ADDRESS 2227 103 S. Jefferson | | Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/> | | |
| 3. NAME OF DECEASED (Type or print) Ella Phillips | | | | First | Middle | Last | 4. DATE OF DEATH Month 6 Day 17 Year 58 | |
| 5. SEX Female 3 | 6. COLOR OR RACE Negro | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 6-12-1895 | | 9. AGE (In years last birthday) 63 | F UNDER 1 YEAR Months | IF UNDER 24 HRS. 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) Arkansas / | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | |
| 13a. FATHER'S NAME unknown | | | 13b. MOTHER'S MAIDEN NAME unknown | | 14. NAME OF HUSBAND OR WIFE Phillips | | | |
| 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. none | 17. INFORMANT Address Eva Mae Armstrong 2607 Caroline | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) HYPERTENSIVE CARDIOVASCULAR DISEASE. | | | | | | | INTERVAL BETWEEN ONSET AND DEATH undet. | |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. | | | DUE TO (b) _____ | | DUE TO (c) 443x | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 2 | |
| 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.) | | | | | |
| 20c. TIME OF INJURY Hour _____ a.m. _____ p.m. | | | | | | | | |
| 20d. INJURY OCCURRED WHILE AT <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 6-9-58 , to 6-17-58 and last saw her ^{her} him alive on 6-17-58 Death occurred at 6:38 A m on the date stated above; and to the best of my knowledge, from the causes stated. | | | | | | | | |
| 22a. SIGNATURE Paul M. Larson (Degree or title) M.D. | | | | 22b. ADDRESS 2601 Whittier Street | | 22c. DATE SIGNED 6-17-58 | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE 6-20-58 | 23c. NAME OF CEMETERY OR CREMATORY Washington Park | | 23d. LOCATION (City, town, or county) St. Louis Co. Mo. (State) | | | | |
| 24. FUNERAL DIRECTOR Dunn Funeral Home 215 So. Jefferson ADDRESS | | | 25. DATE RECD. BY LOCAL REG. JUN 18 58 | | 26. REGISTRAR'S SIGNATURE J. Carl Smith, M.D. S.P. | | | |

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 L. Heilman*

Licensed Embalmer No. *4228*
P. O. Address *3100 Easter*

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.