

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-001476

STATE FILE NUMBER

283

FILED JAN 28 1959

Registration District No. 149

Primary Registration District No. 1602

Registrar's No.

300
1-57

1. PLACE OF DEATH a. COUNTY Jackson			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Cooper		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kansas City		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN Otterville 0270		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Osteopathic Hosp		Length of stay in lb 5 days	d. STREET ADDRESS (If outside, give location) 6 mi North Syracuse		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last CLARENCE EDGAR PHILLIPS			4. DATE OF DEATH Month Day Year 1 14 59		
5. SEX Ma	6. COLOR OR RACE Wh	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-24-1883	9. AGE (In years) 75 IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farming	11. BIRTHPLACE (City and state or country) Cooper County, Mo.		12. CITIZEN OF WHAT COUNTRY? USA
13a. FATHER'S NAME Charles Spencer Phillips		13b. MOTHER'S MAIDEN NAME Matilda Barnhardt		14. NAME OF HUSBAND OR WIFE Stella G. 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 Max Phillips, 209 S. Jackson, KC Mo		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory Center Depression Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Cerebral Vascular Hemorrhage DUE TO (c) Arteriosclerosis					INTERVAL BETWEEN ONSET AND DEATH 3 days 5 days unknown
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Diabetes Mellitus					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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 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 Jan 10, 1959 to Jan 14, 1959 and last saw him alive on Jan 14, 1959 Death occurred at 3:10 p.m. on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) Verner J. Ames			22b. ADDRESS 926 E. 11th St.		22c. DATE SIGNED 1-15-59
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE 1-14-59	23c. NAME OF CEMETERY OR CREMATORY Syracuse Cemetery		23d. LOCATION (City, town, or county) (State) Syracuse, Mo.
24. FUNERAL DIRECTOR Wagner Funeral Home, K C Mo		ADDRESS	25. DATE RECD. BY LOCAL REG. 1-15-59	26. REGISTRAR'S SIGNATURE Irene Marshall	

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

Verner J. Ames

All diseases in Part I must be causally related.

11/11/80
02121

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 *Thomas P. Kuller*

Licensed Embalmer No. *4095*

P. O. Address *H.C. Mc...*

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.