

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-012304  
STATE FILE NUMBER

FILED MAY 4 1959 Registration District No. 38 Primary Registration District No. 3006 Registrar's No. 199

300  
1-57

1. PLACES OF DEATH a. COUNTY <u>Boone</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>Oregon</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Columbia</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Couch</u> 7500 Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>University of Mo</u>		Length of stay in lb	d. STREET ADDRESS (If outside, give location) Reside on Form Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>Mary Ann Phillips</u>			4. DATE OF DEATH Month Day Year <u>Apr 28-1959</u>
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6-27-45</u>
9. AGE (In years last birthday) <u>13 1/2</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>At Home Child</u>	11. BIRTHPLACE (City and state or country) <u>Springfield Mo</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Ray Henry Phillips</u>	14. NAME OF HUSBAND OR WIFE <u>Hospital Records</u>
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>-</u>	17. INFORMANT <u>HOSPITAL RECORDS</u>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Arrest - post operative - open cardiovascular</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <u>Tumors Arteriosclerosis + Intermittent Atrial Defect</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (c) <u>7542</u>			INTERVAL BETWEEN ONSET AND DEATH
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.) <u>ITEM 25 CORRECTED</u>	
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.		BY AFFIDAVIT OF <u>Registrar</u> <u>5-12-59</u>	
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 <u>3/25/59</u> to <u>4/28/59</u> and last saw <sup>her</sup> <sub>him</sub> alive on <u>4/28/59</u> Death occurred at <u>12:05</u> p.m. on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>Earl J. Whipple, Jr.</u> (Degree or title)		22b. ADDRESS <u>M. D. U. of Mo. Medical Center</u>	22c. DATE SIGNED <u>4/28/59</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u>	23b. DATE <u>4/28/1959</u>	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City, town, or county) (State) <u>THAYER MISSOURI</u>
24. FUNERAL DIRECTOR <u>PARKER FUNERAL SERVICE</u>		ADDRESS <u>Columbia Mo</u>	25. DATE RECD. BY LOCAL REG. <u>Apr 28 1959</u>
26. REGISTRAR'S SIGNATURE <u>Mrs. R.E. Palmer</u>			

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
MEDICAL CERTIFICATION  
Doctor, coroner, etc. must use only standard nomenclature. No symptoms will be listed.  
All diseases in Part I must be causally related.

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 *James Hillig* .....

Licensed Embalmer No. *4897* .....

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