

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-015539

STATE FILE NUMBER
2-1107

FILED MAY 12 1959

Registration District No. Primary Registration District No.

300

-57

092
0

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. 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 Jewish Hospital		Length of stay in 1b	d. STREET ADDRESS (If outside, give location) 3938a Blaine Ave. Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First ADALINE Middle M. Last PHILLIPS			4. DATE OF DEATH Month Apr. Day 26 Year 1959		
---	--	--	--	--	--

5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 28, 1898	9. AGE (In years last birthday) 60	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) Tobacco Worker-Liggett & Myers Tobacco Co.	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) St. Louis, Mo.	12. CITIZEN OF WHAT COUNTRY? U.S.A.
--	-----------------------------------	---	---

13a. FATHER'S NAME Thomas Phillips	13b. MOTHER'S MAIDEN NAME Rosalie Streistrecke	14. NAME OF HUSBAND OR WIFE -----
--	--	---

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give year or dates of service) No None	16. SOCIAL SECURITY NO.	17. INFORMANT Esther Phillips	Address 3938a Blaine Ave.
---	-------------------------	---	-------------------------------------

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis, left.		INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	332x	
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"/>

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 March 27, 1959 to April 26, 1959 and last saw ^{her} him alive on April 26, 1959 Death occurred at 10:00 P. m on the date stated above; and to the best of my knowledge, from the causes stated.
--

22a. SIGNATURE Dr. J. J. Gitt, M. D.	22b. ADDRESS 100 N. Euclid, St. Louis 8, Mo.	22c. DATE SIGNED 4-27-59
---	--	------------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE Apr. 29, 1959	23c. NAME OF CEMETERY OR CREMATORY Memorial Park Cemetery	23d. LOCATION (City, town, or county) (State) St. Louis Co. Mo.
---	-----------------------------------	---	---

24. FUNERAL DIRECTOR Kriegshauser	ADDRESS 4228 S. Kingshighway	25. DATE RECD. BY LOCAL REG. APR 27 '59	26. REGISTRAR'S SIGNATURE M. B. [Signature] Smith, M.D.
---	--	---	---

All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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 *Edwin A. McArthur*

Licensed Embalmer No. *3024*

P. O. Address

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.