

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-026289

FILED VS JUL 27 1959

STATE FILE NUMBER

Registration District No. 310 Primary Registration District No. 3058 Registrar's No. 172

1. PLACE OF DEATH a. COUNTY <b>St Charles</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> COUNTY <b>St Charles</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St Charles</b>		Length of stay in 1b <b>2 wks</b>	c. CITY OR TOWN <b>St Charles</b> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>St Joseph Hospital</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>Highway 40</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <b>Milo</b> Middle <b>Phillips</b> Last <b>Phillips</b>			4. DATE OF DEATH Month <b>July</b> Day <b>15</b> Year <b>1959</b>			
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5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>3/28/1897</b>	9. AGE (last birthday) <b>62</b>	IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	IF UNDER 24 HR Hours <input type="checkbox"/> Min. <input type="checkbox"/>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Steam Boat Capt.</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>River Boat</b>	11. BIRTHPLACE (City and state or country) <b>Hamburg Ill</b>	12. CITIZEN OF WHAT COUNTRY <b>USA</b>
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13a. FATHER'S NAME <b>Frank Phillips</b>	13b. MOTHER'S MAIDEN NAME <b>Lulu Gordon</b>	14. NAME OF HUSBAND OR WIFE <b>PAULINE PHILLIPS</b>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <b>No</b>	16. SOCIAL SECURITY NO. <b>487-22-9436</b>	17. INFORMANT <b>Mrs Phillips St Charles Mo.</b>
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) <b>Pneumonia</b>		<b>2 day</b>
DUE TO (b) <b>Carcinoma of Lung</b>		<b>2 yr</b>
DUE TO (c)		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown

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.)
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20c. TIME OF INJURY Hour <input type="checkbox"/> a.m. <input type="checkbox"/> p.m. <input type="checkbox"/>	Month, Day, Year
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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
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21. I attended the deceased from July 8, 1955 to July 15, 1955 and last saw her alive on July 14, 1955  
Death occurred at 8:20 p m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <b>Wm H Poggenmeyer MD</b> (Degree or title)	22b. ADDRESS <b>St Charles, Mo</b>	22c. DATE SIGNED <b>July 16, 1955</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>July 18-1959</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Oak Grove</b>	23d. LOCATION (City, town, or county) (State) <b>Jerseyville Ill</b>
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24. FUNERAL DIRECTOR <b>Kreihauer' St Louis Mo</b>	25. DATE RECD. BY LOCAL REG. <b>July 15-59</b>	26. REGISTRAR'S SIGNATURE <b>Barbara Wilson</b>
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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

6961 8 8 700

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed David P. Baw

Licensed Embalmer No. 5060

P. O. Address St. Charles

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.