

# RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-029864

FILED VS SEP 15 1959 236

Registration District No. 5819 Registrar's No. 48

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <b>MORGAN</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>MORGAN</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) <b>Osage-</b>		Length of stay in 1b <b>10 yrs</b>	c. CITY OR TOWN <b>BARNETT</b> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>6-mi. S-W-BARNETT</b>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>6mi. S-W-BARNETT</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <b>Ida-</b> Middle <b>Lee-</b> Last <b>Phillips</b>			4. DATE OF DEATH Month <b>Sept-</b> Day <b>12</b> Year <b>1959</b>			
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5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>20 MAY 1888 7/</b>	9. AGE (last birthday) <b>71</b>	IF UNDER 1 YEAR Months <input type="checkbox"/> Days <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>House-wife</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>At-Home</b>	11. BIRTHPLACE (City and state or country) <b>New-HAVEN-MO</b>	12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>
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13a. FATHER'S NAME <b>John-Coulter</b>	13b. MOTHER'S MAIDEN NAME <b>ELLA-Lister</b>	14. NAME OF HUSBAND OR WIFE <b>Samuel-Phillips</b>
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5. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>	16. SOCIAL SECURITY NO. <b>NONE</b>	17. INFORMANT <b>Mildred-NOSCR-BARNETT-MO</b> Address
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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>Chronic myocarditis and myocardial degeneration</b>		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <b>hypertension</b>	
	DUE TO (c) <b>atherosclerosis</b>	

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 checked="" type="checkbox"/> No <input type="checkbox"/> Unknown
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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.) <b>NONE</b>
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20c. TIME OF INJURY Hour <input type="checkbox"/> a.m. <input type="checkbox"/> p.m. <b>NONE</b>	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.) <b>NONE</b>	20f. CITY, TOWN, OR LOCATION <b>NONE</b>	COUNTY	STATE
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21. I attended the deceased from **1954** to **9-12-59** and last saw her alive on **9-8-59**  
Death occurred at **5:30 A** m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <b>Carl J. Buehler M.D.</b>	22b. ADDRESS <b>ELDON-MO</b>	22c. DATE SIGNED <b>12 Sept-59</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL-</b>	23b. DATE <b>15 Sept-59</b>	23c. NAME OF CEMETERY OR CREMATORY <b>ZION</b>	23d. LOCATION (City, town, or county) (State) <b>St-Louis-Co-MO</b>
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24. FUNERAL DIRECTOR <b>Keith McKays</b>	ADDRESS <b>ELDON-MO</b>	25. DATE RECD. BY LOCAL REG. <b>9-14-59</b>	26. REGISTRAR'S SIGNATURE <b>J L Wash</b>
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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

VS  
JUN 16 1960

FEB 25 1960

JAN 6 1960

**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

*Keith M. Kaye*

Licensed Embalmer No. 3998

P. O. Address

*Eldon M*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to conform 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.