

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH
59-031464
FILED VS SEP 28 1959
38

 Primary Registration District No. **3006**

 Registrar's No. **454**

STATE FILE NUMBER

| | | | | | | | | | | | | | |
|---|--|---|--|---|---|--|---|--|------------------------------------|--|--|----------------|--|
| 1. PLACE OF DEATH a. COUNTY Boone | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Jasper | | | | | | | | | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Columbia | | Length of stay in 1b 15 Days | | c. CITY OR TOWN Joplin | | Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | | | | | | | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR UNIVERSITY OF MISSOURI INSTITUTION Medical Center | | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | d. STREET ADDRESS (If outside, give location) Route 4 - Box 156 | | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | | | | | | |
| 3. NAME OF DECEASED (Type or print) First RUTH Middle MEDDOCK Last PHILLIPS | | | | 4. DATE OF DEATH Month September Day 24 , Year 1959 | | | | | | | | | |
| 5. SEX Female | | 6. COLOR OR RACE White | | 7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | | 8. DATE OF BIRTH 5-13-1941 | | 9. AGE (last birthday) 18 | | IF UNDER 1 YEAR Months Days Hours Min. | | IF UNDER 24 HR | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | | 10b. KIND OF BUSINESS OR INDUSTRY Housewife | | 11. BIRTHPLACE (City and state or country) San Jose, California | | | 12. CITIZEN OF WHAT COUNTRY U.S.A. | | | | | |
| 13a. FATHER'S NAME Dallas Meddock | | | | 13b. MOTHER'S MAIDEN NAME Marie Bartels | | | | 14. NAME OF HUSBAND OR WIFE Jack 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 Columbia, U. of Mo. Medical Center Chart, 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) Cerebral Edema (Hypertensive Encephalopathy) | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH | | | |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. | | | | | | | | | | DUE TO (b) Hypertension | | | |
| | | | | | | | | | | DUE TO (c) Chronic Glomerulonephritis | | | |
| 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 checked="" type="checkbox"/> NO <input 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 a.m. p.m. | | Month, Day, Year | | | | | | | | | | | |
| 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 Sept. 9, 1959 to Sept. 21, 1959 and last saw her ^{per} last Sept. 24, 1959 Death occurred at 7:20 P. m on the date stated above, and to the best of my knowledge, from the causes stated. | | | | | | | | | | | | | |
| 22a. SIGNATURE <i>R. E. Palmer</i> (Degree or title) | | | | | | 22b. ADDRESS University of Mo. Medical Center | | | 22c. DATE SIGNED 9/24/59 | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Removal | | 23b. DATE 9-25-1959 | | 23c. NAME OF CEMETERY OR CREMATORY | | | | 23d. LOCATION (City, town, or county) (State) Joplin, Missouri. | | | | | |
| 24. FUNERAL DIRECTOR ADDRESS Parker Funeral Service, Columbia, Mo. | | | | 25. DATE RECD. BY LOCAL REG. Sept 25 1959 | | 26. REGISTRAR'S SIGNATURE <i>Mrs. R. E. Palmer</i> | | | | | | | |

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

20710 52 111

OCT 20 1959

OCT 26 1959

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 J. W. Phillips
Licensed Embalmer No. 4857

P. O. Address Columbus, Mo

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