

JURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-039694

FILED VS DEC 14 1959 / 28

Primary Registration District No. 2000 Registrar's No. 1325

STATE FILE NUMBER

UNRECORDED

1. PLACE OF DEATH a. COUNTY Greene				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Greene			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Springfield			Length of stay in 1b		c. CITY OR TOWN Springfield		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Johns Hospital			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) 679 McCann		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First WILLIAM Middle E. Last PHILLIPS				4. DATE OF DEATH Month December Day 5, Year 1959			
5. SEX Male	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 27 April 1910	9. AGE (last birthday) 49		IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laundry Co.		10b. KIND OF BUSINESS OR INDUSTRY Sales Manager		11. BIRTHPLACE (City and state or country) Missouri		12. CITIZEN OF WHAT COUNTRY USA	
13a. FATHER'S NAME George Phillips			13b. MOTHER'S MAIDEN NAME Corrine Renno			14. NAME OF HUSBAND OR WIFE Mary Alyce 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. Unknown		17. INFORMANT Address Hospital Records			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uterine fibroid							INTERVAL BETWEEN ONSET AND DEATH 5 minutes
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Thrombosis of post. coronary artery							2 hours
DUE TO (c) Coronary arteriosclerosis							—
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.)			
20c. TIME OF INJURY Hour <input type="checkbox"/> a.m. <input type="checkbox"/> 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 12-5-59 to 12/5/59 and last saw her him alive on 12-5-59 Death occurred at 3:30 a.m. on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) Leil R. Kuman MD				22b. ADDRESS 609 Cherry Springfield, Missouri			22c. DATE SIGNED 12-7-59
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 12/8/59	23c. NAME OF CEMETERY OR CREMATORY St. Mary's Cemetery		23d. LOCATION (City, town, or county) (State) Springfield, Missouri		
24. FUNERAL DIRECTOR KLINGNER MORTUARY, INC. ADDRESS SPRINGFIELD MO			25. DATE RECD. BY LOCAL REG. 12-8-59		26. REGISTRAR'S SIGNATURE Effie S. Melton		

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

jhc

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 Max Flu

Licensed Embalmer No. 407

P. O. Address Spring

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.