

URI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS JUN 27 1960

-60-024860

STATE FILE NUMBER

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 5755

ENDED

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Louis</u>		Length of stay in 1b <u>20 yrs</u>	c. CITY OR TOWN <u>St. Louis</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>City Hospital</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>3527 Osage</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>WILLIAM</u> Middle <u>ARTHUR</u> Last <u>PHILLIPS</u>			4. DATE OF DEATH Month <u>June</u> Day <u>4</u> Year <u>1960</u>		
---	--	--	---	--	--

5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>6/21/1911</u>	9. AGE (last birthday) <u>48 yrs</u>	IF UNDER 1 YEAR Months Days	IF UNDER 24 HR Hours Min.
-----------------------	----------------------------------	---	--------------------------------------	---	--------------------------------	------------------------------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Driver</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Transport</u>	11. BIRTHPLACE (City and state or country) <u>Lamont, Oklahoma</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
--	---	---	--

13a. FATHER'S NAME <u>William I. Phillips</u>	13b. MOTHER'S MAIDEN NAME <u>Bertha Cruse</u>	14. NAME OF HUSBAND OR WIFE <u>Unknown</u>
--	--	---

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>	16. SOCIAL SECURITY NO. <u>XXXXXXXXXX</u>	17. INFORMANT <u>Eula Mae Stewart</u> Address <u>3527 Osage</u>
---	---	--

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) <u>Terminal pneumonia</u>		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>Perforation of the stomach</u>	
	DUE TO (c) <u>Esophageal varices ruptured</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a). <u>Cirrhosis of the Liver</u>		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.) <u>581-0</u>
--	---	--

20c. TIME OF INJURY Hour <u>          </u> a.m. <u>          </u> p.m. Month, Day, Year <u>          </u>	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 330 P. to            and last saw her/him alive on           .  
Death occurred at            on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>[Signature]</u> (Degree or title)	22b. ADDRESS <u>1300 Class</u>	22c. DATE SIGNED <u>6-6-60</u>
--	-----------------------------------	-----------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u>	23b. DATE <u>6/6/60</u>	23c. NAME OF CEMETERY OR CREMATORY <u>SOUTH-PARK CEMETERY</u>	23d. LOCATION (City, town, or county) (State) <u>HARRIS COUNTY, TEXAS</u>
---	----------------------------	--	--

24. FUNERAL DIRECTOR <u>BEIDERWIEDEN R.H. INC., 1936 ST. LOUIS AVE</u>	25. DATE RECD. BY LOCAL REG. <u>JUN 6 1960</u>	26. REGISTRAR'S SIGNATURE <u>Earl Smith, M.D.</u>
---	---	--

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

**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 Homer W. Fritz

Licensed Embalmer No. 388

P. O. Address St. Louis

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.