

# JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

**-60-033606**

STATE FILE NUMBER

FILED VS SEP 13 1960

360

Primary Registration District No.

6225

Registrar's No. 181

INDEXED

1. PLACE OF DEATH a. COUNTY <b>Vernon</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> COUNTY <b>Lawrence</b>									
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Washington Township</b>		Length of stay in 1b <b>14 days</b>		c. CITY OR TOWN <b>Marionville</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>							
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>St. Hosp. # 3</b>			Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <b>Unknown</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) First <b>Jesse</b> Middle <b>Emmett</b> Last <b>Phillips</b>				4. DATE OF DEATH Month <b>August</b> Day <b>26</b> Year <b>1960</b>									
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>4-19-82</b>		9. AGE (last birthday) <b>78</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"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer &amp; Carpenter</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Unknown</b>		11. BIRTHPLACE (City and state or country) <b>Tennessee</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>					
13a. FATHER'S NAME <b>James Anderson Phillips</b>				13b. MOTHER'S MAIDEN NAME <b>Sarah Johnson</b>				14. NAME OF HUSBAND OR WIFE <b>Lottie Phillips</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Unknown</b>				16. SOCIAL SECURITY NO. <b>500-09-0653</b>		17. INFORMANT <b>Records of</b> Address <b>State Hospital # 3, Nevada, Mo.</b>							
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>Broncho Penumonia</b>													
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.													
DUE TO (b) <b>Coronary Vessel Disease</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) <b>CBS Assoc. with Disturbance of Metabolism, Growth or Nutrition, with Senile Brain Disease, without Qualifying Disease</b>								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 <b>August 12, 1960</b> to <b>8-26-60</b> and last saw <sup>him</sup> <del>her</del> alive on <b>August 26, 1960</b> Death occurred at <b>6:40</b> a. m on the date stated above, and to the best of my knowledge, from the causes stated.													
22a. SIGNATURE <i>Ellen Pickens MD</i> <b>Ellen Pickens MD</b>				22b. ADDRESS <b>St. Hosp. # 3, Nevada, Mo.</b>				22c. DATE SIGNED <b>8-26-60</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial, 500</b>		23b. DATE <b>Aug. 28, 1960</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Odd Fellows Cemetery</b>		23d. LOCATION (City, town, or county) <b>Marionville, Missouri.</b>		(State)					
24. FUNERAL DIRECTOR <i>J. B. Surridge</i> <b>J. B. Surridge</b>				ADDRESS <b>Marionville, Mo.</b>		25. DATE RECD. BY LOCAL REG. <b>9-6-1960</b>		26. REGISTRAR'S SIGNATURE <i>Arma E. Jarry</i>					

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

SEP 13 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 William A. Fulkes

Licensed Embalmer No. 4658

P. O. Address Marionick

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.