

FRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-038837

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Primary Registration District No. 3032 Registrar's No. 128

STATE FILE NUMBER

|                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                           |                                                                                      |                                                                                                                                                             |                                                                               |                                                                                      |                                                                                       |                                                                                                                                                                      |  |                                                    |  |                 |  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------|--------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------|--|-----------------|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Johnson</b>                                                                                                                                                                                                                                                                                            |  |                                                                                                           |                                                                                      | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Missouri</b> b. COUNTY <b>Johnson</b>                  |                                                                               |                                                                                      |                                                                                       |                                                                                                                                                                      |  |                                                    |  |                 |  |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR<br>TOWN <b>Warrensburg</b>                                                                                                                                                                                                                                               |  | Length of stay in lb<br><b>1 day</b>                                                                      |                                                                                      | c. CITY OR TOWN <b>Holden</b>                                                                                                                               |                                                                               | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |                                                                                       |                                                                                                                                                                      |  |                                                    |  |                 |  |
| c. FULL NAME OF (If NOT in hospital, give location)<br>HOSPITAL OR INSTITUTION <b>Medical Center Hosp.</b>                                                                                                                                                                                                                               |  |                                                                                                           | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |                                                                                                                                                             | d. STREET ADDRESS (If outside, give location)<br><b>3rd &amp; Olive Sts.,</b> |                                                                                      | Reside on Farm<br>Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |                                                                                                                                                                      |  |                                                    |  |                 |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>HARRY</b> Middle Last <b>PHIPPS</b>                                                                                                                                                                                                                                                      |  |                                                                                                           |                                                                                      | 4. DATE OF DEATH<br>Month <b>Oct.</b> Day <b>17,</b> Year <b>1960</b>                                                                                       |                                                                               |                                                                                      |                                                                                       |                                                                                                                                                                      |  |                                                    |  |                 |  |
| 5. SEX<br><b>male</b>                                                                                                                                                                                                                                                                                                                    |  | 6. COLOR OR RACE<br><b>white</b>                                                                          |                                                                                      | 7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/><br>Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> |                                                                               | 8. DATE OF BIRTH<br><b>8/19/1879</b>                                                 |                                                                                       | 9. AGE (last birthday)<br><b>81</b>                                                                                                                                  |  | IF UNDER 1 YEAR<br>Months Days Hours Min.          |  | IF UNDER 24 HR. |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>farmer &amp; Merchant</b>                                                                                                                                                                                                              |  |                                                                                                           |                                                                                      | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Own farm</b>                                                                                                        |                                                                               | 11. BIRTHPLACE (City and state or country)<br><b>Blairstown, Mo.</b>                 |                                                                                       | 12. CITIZEN OF WHAT COUNTRY<br><b>U.S.A.</b>                                                                                                                         |  |                                                    |  |                 |  |
| 13a. FATHER'S NAME<br><b>David Phipps</b>                                                                                                                                                                                                                                                                                                |  |                                                                                                           |                                                                                      | 13b. MOTHER'S MAIDEN NAME<br><b>Cornelia Wall</b>                                                                                                           |                                                                               |                                                                                      |                                                                                       | 14. NAME OF HUSBAND OR WIFE<br><b>none</b>                                                                                                                           |  |                                                    |  |                 |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><b>no</b>                                                                                                                                                                                                                    |  |                                                                                                           |                                                                                      | 16. SOCIAL SECURITY NO.<br><b>xxxx</b>                                                                                                                      |                                                                               | 17. INFORMANT<br><b>Paul Phipps,</b>                                                 |                                                                                       | Address<br><b>Holden, Missouri.</b>                                                                                                                                  |  |                                                    |  |                 |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Myocardial Infarction</b><br>DUE TO (b) <b>Arteriosclerotic heart disease</b><br>DUE TO (c) <b>eyes</b><br>Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. |  |                                                                                                           |                                                                                      |                                                                                                                                                             |                                                                               |                                                                                      |                                                                                       |                                                                                                                                                                      |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>6 weeks</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.<br><input type="checkbox"/> Yes <input type="checkbox"/> N. <input type="checkbox"/> Unknown |  |                                                    |  |                 |  |
| 19. WAS AUTOPSY PERFORMED?<br>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<br>Hour <b>3:45 P</b><br>a.m. p.m.                                                                                                                                                                                                                                                                                   |  | Month, Day, Year<br><b>8-13-57</b>                                                                        |                                                                                      |                                                                                                                                                             |                                                                               |                                                                                      |                                                                                       |                                                                                                                                                                      |  |                                                    |  |                 |  |
| 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>8-13-57</b> to <b>10-17-60</b> and last saw her alive on <b>10-17-60</b><br>Death occurred at <b>3:45 P</b> on the date stated above, and to the best of my knowledge, from the causes stated.                                                                                                       |  |                                                                                                           |                                                                                      |                                                                                                                                                             |                                                                               |                                                                                      |                                                                                       |                                                                                                                                                                      |  |                                                    |  |                 |  |
| 22a. SIGNATURE<br><b>[Signature]</b> (Degree or title) <b>M.D.</b>                                                                                                                                                                                                                                                                       |  |                                                                                                           |                                                                                      | 22b. ADDRESS<br><b>Warrensburg, Mo.</b>                                                                                                                     |                                                                               |                                                                                      |                                                                                       | 22c. DATE SIGNED<br><b>10/19/60</b>                                                                                                                                  |  |                                                    |  |                 |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>                                                                                                                                                                                                                                                                               |  | 23b. DATE<br><b>10/19/1960</b>                                                                            |                                                                                      | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Wall Cemetery</b>                                                                                                  |                                                                               | 23d. LOCATION (City, town, or county) (State)<br><b>Blairstown, Missouri.</b>        |                                                                                       |                                                                                                                                                                      |  |                                                    |  |                 |  |
| 24. FUNERAL DIRECTOR<br><b>Canaday &amp; Ropp, Holden, Missouri</b>                                                                                                                                                                                                                                                                      |  |                                                                                                           |                                                                                      | ADDRESS                                                                                                                                                     |                                                                               | 25. DATE RECD. BY LOCAL REG.<br><b>Oct. 19, 1960</b>                                 |                                                                                       | 26. REGISTRAR'S SIGNATURE<br><b>Savannah Crutchfield</b>                                                                                                             |  |                                                    |  |                 |  |

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

DEC 27 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 M L Canada

Licensed Embalmer No. 3434

P. O. Address Holden, Miss

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