

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 5604

FILED FEB 26 1952

BIRTH NO. _____		REG. DIST. NO. <u>172</u>		PRIMARY REG. DIST. NO. <u>4270</u>		Registrar's No. <u>17</u>	
1. PLACE OF DEATH a. COUNTY <u>Lafayette</u>				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Lafayette</u>			
b. CITY OR TOWN <u>Dover</u>				c. CITY OR TOWN <u>Dover</u>			
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Home, Dover</u>				d. STREET ADDRESS (If rural, give location) <u>Dover, Missouri</u>			
3. NAME OF DECEASED (Type or Print) <u>CAROLINE</u>				a. (First) <u>PHILIPPS</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>February 12 1952</u>	
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u>		8. DATE OF BIRTH <u>October 29 1857</u>	
9. AGE (In years last birthday) <u>94</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		11. BIRTHPLACE (State or foreign country) <u>Herman, Missouri</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13a. FATHER'S NAME <u>Charles Kaiser</u>		13b. MOTHER'S MAIDEN NAME <u>Johanna Osner</u>		14. NAME OF HUSBAND OR WIFE <u>Martin Philipps</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT'S SIGNATURE OR NAME <u>Frank C. Philipps</u> ADDRESS <u>Dover, Missouri</u>			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death. 1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Senility</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. 19a. DATE OF OPERATION _____				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT SUICIDE HOMICIDE (Specify) _____		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____		21c. (CITY, TOWN, OR TOWNSHIP) _____ (COUNTY) _____ (STATE) _____			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? _____			
22. I hereby certify that I attended the deceased from <u>June 2, 1952</u> , to <u>2/12, 1952</u> , that I last saw the deceased alive on <u>3/11, 1952</u> , and that death occurred at <u>1:15 p.m.</u> , from the causes and on the date stated above.							
23a. SIGNATURE <u>[Signature]</u> (Degree or title) <u>Dr.</u>				23b. ADDRESS <u>[Signature]</u>		23c. DATE SIGNED <u>2/13/52</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>Feb. 14, 1952</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Dover Cemetery</u>		24d. LOCATION (City, town, or county) (State) <u>Dover, Missouri</u>	
DATE REC'D BY LOCAL REG. <u>Feb 22 - 1952</u>		REGISTRAR'S SIGNATURE <u>Chyten H. Landrum</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>[Signature]</u> ADDRESS _____			

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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 _____

working under my personal supervision.

Student Embalmer No.

Signed _____

Licensed Embalmer No. 2983

P. O. Address Lexington, Mo

Signed
Student Embalmer

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 this body is not embalmed, fact should be so stated above.