N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

JAN 17 1940

Registration District No. 508

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 3026

State File No. 43928

Registrar's No. 155.

1. PLACE OF DEATH:

(a) County Livingston

(b) City or town Chillicothe (If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: 403 Locust Street (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution (Specify whether

In this community 75-10-18 years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Livingston

(c) City or town Chillicothe (If outside city or town limits, write "RURAL")

(d) Street No. 403 Locust (If rural, give location)

(e) If foreign born, how long in U. S. A.? years.

3. (a) PRINT FULL NAME Robert Sayers Philips 412

3. (b) If veteran, name war No

3. (c) Social Security No. None

4. Sex Male

5. Color or race White

6. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife wife Sofie C. Philips

6. (c) Age of husband or wife if alive years

7. Birth date of deceased Jan. 22 1864 (Month) (Day) (Year)

8. AGE: Years	Months	Days	If less than one day
75	10	18	hr. min.

9. Birthplace Chillicothe Mo. (City, town, or county) 0 (State or foreign country)

10. Usual occupation 1

11. Industry or business Saleman 1

FATHER
12. Name Robert Philips
13. Birthplace Unk. Penn. (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Charlotta Jane Holcomb
15. Birthplace unk. So. Car. (City, town, or county) (State or foreign country)

X 16. (a) Informant's own signature Clara C. Philips

(b) Address 403 Locust St.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 12 1939 (Month) (Day) (Year)

(c) Place: burial or cremation Edgewood Cem.

18. (a) Signature of funeral director F. A. Meinershagen

(b) Address Chillicothe Mo.

19. (a) 12-11-39 (Date received local registrar) (b) H M Grace, M.D. (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 10th year 1939 hour 2:50 am minute 000 M.

21. I hereby certify that I attended the deceased from Nov 18, 1939, to Dec 10, 1939, that I last saw him alive on Dec 9, 1939, and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Carcinoma of pancreas	6 mo
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations —
Of autopsy —

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify)

(b) Date of occurrence

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)

While at work? (e) Means of injury

23. Signature [signature] (M. D. or other)

Address Chillicothe Date signed 12/11/39

943 (Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 11
District File Number 140-1930
Date Filed JAN 13 1940

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 Elmer Thomas, Registered Apprentice No. ..... working under my personal supervision.

Signed Elmer Thomas

Licensed Embalmer No. 2640

P. O. Address Chillicothe

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wi the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.