

FILED FEB 14 1941

Registration District No. 378

Primary Registration District No. 4222-5526

Registrar's No. 7

1. PLACE OF DEATH:

(a) County Howard
(b) City or town Fayette
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
27th St.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community _____ years, months or days

8. (a) PRINT FULL NAME Adolphus Paxton Phillips,

8. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Mary E. Phillips 6. (c) Age of husband or wife if alive 80 years

7. Birth date of deceased June 8th 1854
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
86 7 8 hr. min.

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

10. Usual occupation Farmer

11. Industry or business _____

12. Name James Richard Phillips,

13. Birthplace Kentucky
(City, town, or county) (State or foreign country)

14. Maiden name Nancy Basye,

15. Birthplace Virginia
(City, town, or county) (State or foreign country)

16. (a) Informant V.W. Phillips,

(b) Address Fayette, Mo.

17. (a) Burial (b) Date thereof Jan 17th 1941
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Walnut Ridge,

18. (a) Signature of funeral director Guy T. Halley,
Fayette, Mo.

(b) Address _____

19. (a) 1-19-41 (b) Reuben P. Vandave
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

Missouri, Howard, 45
(a) State (b) County
(c) City or town Fayette, 0
(If outside city or town limit, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) If foreign born, how long in U. S. A.? 0 years

1941 MEDICAL CERTIFICATION

20. DATE OF DEATH: Month _____ day _____
year _____ hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from June 1929 to June 1941
that I last saw him alive on August 1940
and that death occurred on the date and hour stated above.

Immediate cause of death Chronic Cardio-Vascular Disease with terminal uremia

Due to Senility

Due to _____

Other conditions (include pregnancy within 3 months of death) _____

Major findings: Of operations none
Of autopsy none

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? _____

While at work? _____ (Specify type of place) (e) Means of injury _____

22. Signature Wm. J. Shaw (M. D. or other) M.D.
Address Fayette, Mo. Date signed 1-18-41

Duration 5 yrs.

PHYSICIAN Underline the cause to which death should be charged statistically.

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

RECEIVED
District Health Officer No. 8
District File Number
Date Filed 7-13-41

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

Signed Guy T. Haelem
Licensed Embalmer No. 2762
P. O. Address Jayville Mass

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, above space should be left blank.

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-39
K26390

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 27677

Registration District No. 378

Primary Registration District No. 5526

Registrar's No. 7

1. PLACE OF DEATH:

(a) County Howard
(b) City or town Richmond Twp
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution..... (Specify whether
In this community.....
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State..... (b) County.....
(c) City or town..... (If outside city or town limits, write "RURAL")
(d) Street No..... (If rural, give location)
(e) Citizen of foreign country?..... (Yes or No)
If yes, name country.....

3. (a) PRINT FULL NAME

Adolphus Patton Phillis

3. (b) If veteran, name war.....

3. (c) Social Security No.

4. Sex M

5. Color or race W

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

6. (b) Name of husband or wife.....

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

7. Birth date of deceased.....

(Month)

(Day)

(Year)

8. AGE:

Years

Months

Days

If less than one day

86

7

8

hr.

min.

9. Birthplace.....

(City, town, or county)

(State or foreign country)

10. Usual occupation.....

11. Industry or business.....

12. Name.....

13. Birthplace.....

(City, town, or county)

(State or foreign country)

14. Maiden name.....

15. Birthplace.....

(City, town, or county)

(State or foreign country)

16. (a) Informant.....

(b) Address.....

17. (a)..... (b) Date thereof.....

(Burial, cremation, or removal)

(Month) (Day) (Year)

(c) Place: burial or cremation.....

18. (a) Signature of funeral director.....

(b) Address.....

19. (a) 6-17-41 (b) Anna P. Tinsdale

(Date received local registrar)

(Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 15 15-41
year..... hour..... minute..... M.

21. I hereby certify that I attended the deceased from..... 19.....

that I last saw him..... 19.....
and that death occurred on the date and hour stated above.

Immediate cause of death..... Duration

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?

While at work?..... (Specify type of place) (e) Means of injury.....

Signature M. J. Shaw (M. D. or other)

Address Fayette Date signed

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

SUPPLEMENTARY

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

Signed.....

Licensed Embalmer No.....

P. O. Address.....

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.