

Registration District No. 496

Primary Registration District No. 3020

1. PLACE OF DEATH:

(a) County Linn
 (b) City or town Brookfield
 (c) Name of hospital or institution 540 S. Monroe
 (d) Length of stay: In hospital or institution 8 years. 1
 In this community 8 years. 1

3. (a) PRINT FULL NAME EUNICE-ELLEN-PHELPS

8. (b) If veteran, name war _____ 8. (c) Social Security No. none

4. Sex 71 5. Color or race W
 6. (a) Single, widowed, married, divorced, Widowed
 (b) Name of husband or wife Joseph Phelps
 6. (c) Age of husband or wife if alive 30 years
 7. Birth date of deceased July 30 1850

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept. day 26 year 1941 hour 11 minute _____ M.
 21. I hereby certify that I attended the deceased from Sept 26, 1941, to Sept 26, 1941; that I last saw her alive on Sept 26, 1941; and that death occurred on the date and hour stated above.

Immediate cause of death fracture of femur (right - 3rd & 4th epiphysis)
 Due to trauma & arteriosclerosis
 Duration 10 d.

8. AGE: Years 91 Months 1 Days 26 If less than one day hr. _____ min. _____

9. Birthplace Beekmanville, New York
 (City, town, or county) (State or foreign country)

10. Usual occupation House wife

11. Industry or business _____

MOTHER FATHER
 12. Name Linn White
 13. Birthplace LI NY
 (City, town, or county) (State or foreign country)
 14. Maiden name _____
 15. Birthplace LI NY
 (City, town, or county) (State or foreign country)

16. (a) Informant's own signature E. Phelps
 (b) Address Brookfield
 17. (a) Burial (b) Date thereof _____
 (Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation Rose Hill Cemetery - Brookfield
 18. (a) Signature of funeral director Hell Chapel
 (b) Address Brookfield
 19. (a) _____ (b) _____
 (Date received local registrar) (Registrar's signature)

Other conditions (include pregnancy within 3 months of death) 1940
 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) Accident
 (b) Date of occurrence Sept 16 1941 058
 (c) Where did injury occur? Brookfield Linn Mo
 (City or town) (County) (State)
 (d) Did injury occur in or about home, on farm, in industrial place, in public place?
 While at work? No (Specify type of place) (e) Means of injury Fall from
 23. Signature Roy A. Haley (M. D. or other) MO
 Address Brookfield Date signed 9/27/41

I X1851 MAINLY - USE UNFADING BLACK INK - MAKE A PERMANENT RECORD

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.

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.....

J. M. Blacklock
working under my personal supervision.

....., Registered Apprentice No.....

Signed *J. M. Blacklock*

Licensed Embalmer No. *2246*

P. O. Address *Brookfield Va*

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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 35392
Registrar's No.

Registration District No. 496

Primary Registration District No. 3025

1. PLACE OF DEATH:

(a) County Linn
(b) City or town Brookfield
(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

Cornice E. Phelps

3. (b) If veteran, name war

3. (c) Social security No.

4. Sex F

5. Color or race W

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

6. (b) Name of husband or wife

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

7. Birth date of deceased

July 30
(Month) (Day) (Year)

8. AGE:

Years 91

Months 1

Days 2

(If less than one day)

9. Birthplace

(City, town, or county)

(State or foreign country) N.Y.

10. Usual occupation

11. Industry or business

MOTHER FATHER { 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) BURIAL

(Burial, cremation, or removal)

(b) Date thereof

9-28-1941
(Month) (Day) (Year)

(c) Place: burial or cremation

Rose Hill Cem.

18. (a) Signature of funeral director

HILL CHAPEL

(b) Address

Brookfield MD

19. (a) 9-28-41

(Date received local registrar)

(b)

W.H. Cowan

(Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH:

Month Sept Day 28 Year 1941 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ to _____, 19____;

that I last saw him/her alive on _____, 19____; and that death occurred on the date and hour stated above.

Immediate cause of death

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? _____

While at work? _____

(Specify type of place)

(e) Means of injury _____

23. Signature _____

(M. D. or other) _____

Address _____

Date signed _____

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

SUPPLEMENTARY

S-35392