DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED MAY 15 1944

Registration District No. 335

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 15938

Primary Registration District No. 6118

Registrar's No.

1. PLACE OF DEATH:

(a) County: Scott

(b) City or town: R.F.D. Oran Mo. Sainsoma
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: 0
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution ..... (Specify whether years, months or days)
In this community .....

2. USUAL RESIDENCE OF DECEASED:

(a) State: Mo. (b) County: Scott

(c) City or town: Oran (If outside city or town limits, write "RURAL") Rural

(d) Street No. ..... (If rural, give location) 0

(e) Citizen of foreign country? No. (Yes or No)

If yes, name country: 0

3. (a) PRINT FULL NAME: Herman Harley Philips

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

3. (c) Social Security No. .....

4. Sex: Male 0

5. Color or race: White

6. (a) Single, widowed, married, divorced: 0

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

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

7. Birth date of deceased: 1/14/ (Month) 10 (Day) 1944 (Year)

8. AGE: Years ..... Months ..... Days 4 ..... If less than one day ..... hr. ..... min.

9. Birthplace: R.F.D. Oran (City, town, or county) Mo. 0 (State or foreign country)

10. Usual occupation: ✓

11. Industry or business: ✓

FATHER
12. Name: Harley Velmer Philips
13. Birthplace: Lamar (City, town, or county) Ark. 1 (State or foreign country)

MOTHER
14. Maiden name: Hattie Willie Bolty
15. Birthplace: Lamar (City, town, or county) Ark. 1 (State or foreign country)

16. (a) Informant: Mrs. Harley Philips

(b) Address: R.F.D. Oran Mo.

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

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

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

(b) Address .....

19. (a) 5/16/44 (Date received by local registrar) (b) G.D. Eckman (Registrar's signature) Oran Mo.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 4 day n 14 year 1944 hour 4 minute 20 P.M.

21. I hereby certify that I attended the deceased from ....., 19..., to ....., 19...; that I last saw h..... alive on ....., 19...; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death	
Due to: Pneumonia ✓	
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: Clyde Pace (Coroner) (Not another)

Address: Sikeston Mo. Date signed 4/14/44

(Licensed Embalmer's Statement on Reverse Side)

15

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

RECEIVED
District Health Office No
District File Number 544-7
Date Filed 5-11-44

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 wi the above constitutes grounds for revocation of license.)

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

o. 2B
-5-43
X36930

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. May

Registration District No. 335 Primary Registration District No. 6118 Registrar's No.

SUPPLEMENTARY

1. PLACE OF DEATH:

(a) County Scott

(b) City or town (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 Herman H. Philips

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

6. (b) Name of husband or wife

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

7. Birth date of deceased April (Month) 10 (Day) 1944 (Year)

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

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

10. Usual occupation

11. Industry or business

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

MOTHER
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 Apr 15 1944 (Month) (Day) (Year)

(c) Place: burial or cremation Friend cemetary Oran Mo

18. (a) Signature of funeral director Heisserer Funeral Mo

(b) Address Oran Mo.

19. (a) 5/4/44 (Date received local registrar) (b) H Slickman (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 14 year 1944 hour minute M.

21. I hereby certify that I attended the deceased from , 19 to , 19 ; that I last saw h alive on , 19 ; and that death occurred on the date and hour stated above.

Immediate cause of death Pneumonia Bronchial

Due to

Due to N. M. O.

Other conditions (Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy

107

Duration

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 Lyde Poe (M. D. of other) Corner

Address Seville Mo Date signed

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