

FILED OCT 11 1944

Registration District No. **187**

Primary Registration District No. **3040**

Registrar's No. **112**

1. PLACE OF DEATH

(a) County **Swainston**  
(b) City or town **Chillicothe**  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
**315 Bridge St**  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution **1**  
(Specify whether

In this community  
years, months or days)

3. (a) PRINT FULL NAME

**Paul Ray Phillips**

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 **Single**

6. (b) Name of husband or wife

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

7. Birth date of deceased **SEPT 15 1944**  
(Month) (Day) (Year)

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

9. Birthplace **Chillicothe MO**  
(City, town, or county) (State or foreign country)

10. Usual occupation

11. Industry or business

12. Name **Herbert Phillips**

13. Birthplace **Sturgis MO**  
(City, town, or county) (State or foreign country)

14. Maiden name **Mrs. Bell Robinson**

15. Birthplace **Swainston County MO**  
(City, town, or county) (State or foreign country)

16. (a) Informant **Herbert Phillips**

(b) Address **Chillicothe MO**

17. (a) **Burial** (b) Date thereof **9-17-44**  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Chillicothe, Wallace Cem**

18. (a) Signature of funeral director **W. E. Keith 3227**

(b) Address **Chillicothe MO**

19. (a) **SEPT 16** (b) **Law E. H. Curry**  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **MO** (b) County **Swainston**  
(c) City or town **Chillicothe MO**  
(If outside city or town limits, write "RURAL")  
(d) Street No. **315 Bridge**  
(If rural, give location)  
(e) Citizen of foreign country? (Yes or No)  
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Sept** day **16**  
year **1944** hour **4** minute **15 P.M.**

21. I hereby certify that I attended the deceased from **Sept 15 1944** to **Sept 16 1944**  
that I last saw him alive on **Sept 16**  
and that death occurred on the date and hour stated above.

Immediate cause of death **Premature  
birth (7 mo uterine  
gestation)**

Due to **Unknown**

Due to **Star**

Other conditions  
(Include pregnancy within 3 months of death)

Major findings:  
Of operations

Of autopsy

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

(c) 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 **W. E. Keith** (City or town) **Chillicothe MO**  
Address **Sept 16 1944** Date signed

Duration

**2 days**

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

MOTHER FATHER

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 Was not Embalmed Registered Apprentice No. \_\_\_\_\_  
working under my personal supervision.

Signed E. Beckwith

Licensed Embalmer No. 3227

P. O. Address Chillum the MD

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.