

FILED APR 18 1947

Registration District No. 290

Primary Registration District No. 5983

Registrar's No. 31

1. PLACE OF DEATH  
(a) County Pulaski  
(b) City or town Rollin Township  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
on Highway 66 in Rm. Hospital 3  
(If hospital or institution, give 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 MO (b) County Pulaski 85  
(c) City or town Richland  
(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 MARY MADGE LING PHILLIPS  
3. (b) If veteran, name war.....  
3. (c) Social Security No. 499-03-190A  
4. Sex F 1 5. Color or race w  
6. (a) Single, widowed, married, divorced widow  
6. (c) Age of husband or wife if alive..... years  
7. Birth date of deceased June 4 1879  
(Month) (Day) (Year)

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month 3 day 6th  
year 1947 hour 2 minute 30 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.

8. AGE: Years 67 Months 9 Days 2 If less than one day hr. min.  
9. Birthplace Brunley MO  
(City, town, or county) (State or foreign country)  
10. Usual occupation Housewife  
11. Industry or business.....  
12. Name Jack Reed  
13. Birthplace Brunley MO  
(City, town, or county) (State or foreign country)  
14. Maiden name Louisa White  
15. Birthplace Richland MO  
(City, town, or county) (State or foreign country)  
16. (a) Informant Stoman Phillips  
(b) Address Richland MO  
17. (a) Burial (b) Date thereof 3 11 47  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation.....  
18. (a) Signature of funeral director W B Jeepe  
(b) Address Richland MO  
19. (a) 3-26-47 (b) James B McClintock  
(Date received local registrar) (Registrar's signature)

Immediate cause of death Suicide Duration  
Due to Blinking Silver Peating & Pulasky Legend  
Due to.....  
Other conditions (Include pregnancy within 3 months of death)  
Major findings:  
Of operations.....  
Of autopsy.....  
16 3/8  
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) Suicide  
(b) Date of occurrence 3/6-1947  
(c) Where did injury occur? Richland Pulaski MO  
(City or town) (County) (State)  
(d) Did injury occur in or about home, on farm, in industrial place, in public place?  
Residence  
While at work?..... (Specify type of place)  
(e) Means of injury 3  
23. Signature W B Jeepe (M. D. or other)  
Address Richland MO Date signed 3/4/47

**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.....

*Art Bunch*

Registered Apprentice No. *484*

working under my personal supervision.

Signed.....

*RA Juper*

Licensed Embalmer No. *3198*

P. O. Address. *Richland Mo.*

**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.**

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. May  
Registrar's No. 31

Registration District No. 290

Primary Registration District No. 5993

1. PLACE OF DEATH:

(a) County Pulaski  
(b) City or town Rural  
(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) (Specify whether

3. (a) PRINT FULL NAME

Mary M. Phillips

(b) If veteran, name war \_\_\_\_\_ (c) Social Security No. \_\_\_\_\_

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced wid  
6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased: June 4 1947  
(Month) (Day) (Year)

8. AGE: Years 67 Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

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) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_ (Month) (Day) (Year)  
(Burial, cremation, or removal)

(c) Place: burial or cremation \_\_\_\_\_

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

(b) Address \_\_\_\_\_

19. (a) 3-26-47 (b) Louise B. McClintock  
(Date received local registrar) (Registrar's signature)

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 \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May 1947 year \_\_\_\_\_ floor \_\_\_\_\_ minute \_\_\_\_\_ M.  
21. I hereby certify that I attended the deceased from \_\_\_\_\_ to \_\_\_\_\_, 19\_\_\_\_; that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_; and that death occurred on the date and hour stated above.  
Immediate cause of death \_\_\_\_\_

Duration

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 \_\_\_\_\_

SUPPLEMENTARY

14577