

FILED AUG 20 1947

Registration District No. _____

Primary Registration District No. 3000

Registrar's No. 218

1. PLACE OF DEATH:

(a) County Adair

(b) City or town Kirksville
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
510 E. Illinois
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution None
(Specify whether years, months or days)

In this community Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Adair

(c) City or town Kirksville
(If outside city or town limits, write "RURAL")

(d) Street No. 510 E. Illinois
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Charlotta T. Phipps

3. (b) If veteran, name war _____ 3. (c) Social Security No. None

4. Sex F / 5. Color of race W 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife F. M. Phipps 6. (c) Age of husband or wife if alive 75 years

7. Birth date of deceased Sept. 2 1872
(Month) (Day) (Year)

8. AGE: Years 74 Months 11 Days 1 If less than one day _____ hr. _____ min.

9. Birthplace Adair Co. Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation Home

11. Industry or business _____

12. Name Peter H. More

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

14. Maiden name Susan Smith

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

16. (a) Informant F. M. Phipps

(b) Address Kirksville, Mo

17. (a) Burial (b) Date thereof 8/5/47
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Forest Cemetery

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

(b) Address Kirksville, Missouri

19. (a) 8-14-47 (b) Kate Lambert
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug. day 3
year 1947 hour 7:30 minute _____ P: _____ M.

21. I hereby certify that I attended the deceased from July 2 to July 3, 1947.
that I last saw her alive on July 3, 1947 and that death occurred on the date and hour stated above.

Immediate cause of death Subacute bacterial pneumonia
Due to influenza infection

Due to _____

Other conditions ✓
(Include pregnancy within 3 months of death)

Major findings: ✓
Of operations ✓
Of autopsy No

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 T. J. Carmichael (M. D. or other)
Address Kirksville, Mo Date signed 8-5-47

Duration _____

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

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

MOTHER FATHER

RECEIVED
District Health Officer No. 10
District File Number 8-47-102
Date Filed AUG 19 1947

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.....
..... Kenneth Slavens....., Registered Apprentice No. 418
working under my personal supervision.

Signed *D. E. Riley*
Licensed Embalmer No. 4181
P. O. Address Kirksville, 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.