

FILED OCT 23 1947

Registration District No. **343**

Primary Registration District No. **6157**

Registrar's No. **37**

1. PLACE OF DEATH:

(a) County **Stoddard**  
(b) City or town **Morehouse rural**  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: **Home**  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution.....  
In this community **3 1/2 years**  
(Specify whether years, months or days).

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo** (b) County **Stoddard / 13**  
(c) City or town **Morehouse rural**  
(If outside city or town limits, write "RURAL")  
(d) Street No.....  
(If rural, give location)  
(e) Citizen of foreign country? **No** (Yes or No)  
If yes, name country.....

3. (a) PRINT FULL NAME **Bonnie Carol Phillipps**

3. (b) If veteran, name war..... 3. (c) Social Security No.....

4. Sex **Female** 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 **September 20, 1946**  
(Month) (Day) (Year)

8. AGE: Years **1** Months **13** Days **0** If less than one day hr. min.

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

10. Usual occupation.....

11. Industry or business.....

12. Name **Leonard Phillipps**  
13. Birthplace **Lawrence Co Ark 1**  
(City, town, or county) (State or foreign country)  
14. Maiden name **Nellie Nicholas**  
15. Birthplace **Lawrence Ark 1**  
(City, town, or county) (State or foreign country)

16. (a) Informant **F. Coffey**  
(b) Address **Sikeston R3 Mo**

17. (a) **Rural** (b) Date thereof **10-3-1947**  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Sikeston Mo**

18. (a) Signature of funeral director **W. H. Winters**  
(b) Address **Dexter Mo**

19. (a) **9-18-47** (b) **Kate Hamels**  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **10** day **3**  
year **1947** hour **11** minute **00 A.M.**

21. I hereby certify that I attended the deceased from **10-2**  
....., 19**47**, to **10-3**....., 19**47**.  
that I last saw her alive on **10-3**....., 19**47**,  
and that death occurred on the date and hour stated above.

Immediate cause of death **Lobar Pneumonia**  
Duration **3 days**

Due to.....

Due to.....

Other conditions **Whooping Cough** **3 weeks**  
(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 **J. M. Davis** (M. D. or other) **0**  
Address **Morehouse, Mo** Date signed **10-3-47**

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

MOTHER FATHER

RECEIVED

District Health Office No. 2,

District File Number *101-1374*

Date Filed *10-20-47*

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.....

*Not embalmed*

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

working under my personal supervision.

Signed *Ryman Steele*

Licensed Embalmer No. *2476*

P. O. Address *Wester 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.