

Registration District No. **317**

Primary Registration District No. **6076**

1. PLACE OF DEATH:

(a) County **ST. LOUIS**  
(b) City or town **PINE LAWN**  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
**4420 RAVENWOOD 1**  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether)  
In this community **3 YEARS**  
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State **MISSOURI** (b) County **ST. LOUIS 96**  
(c) City or town **PINE LAWN**  
(If outside city or town limits, write "RURAL.")  
(d) Street No. **4420 RAVENWOOD**  
(If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME **ESTES L. 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 **3**  
6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased **APR-15-1861**  
(Month) (Day) (Year)

8. AGE: Years **86** Months **8** Days **13** If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace **LE CLAIRE - IOWA**  
(City, town or county) (State or foreign country)

10. Usual occupation **FARMER**

11. Industry or business \_\_\_\_\_

MOTHER FATHER  
12. Name **LORRAINE PHILLIPS**  
13. Birthplace **PA**  
(City, town or county) (State or foreign country)  
14. Maiden name **ADELINE CONLER**  
15. Birthplace **PA**  
(City, town or county) (State or foreign country)

16. (a) Informant **Paul H. Phillips**  
(b) Address **5363 20 Union**

17. (a) **CREMATION** (b) Date thereof **12-31-47**  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **VALHALLA CREMATORY**

18. (a) Signature of funeral director **L. B. Farmer**

(b) Address **607 Natural Bridge**

19. (a) **12-31-47** (b) **Beulah**  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **12** day **28**  
year **1947** hour **12** minute **15 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.  
Immediate cause of death \_\_\_\_\_

Cause unknown

Due to **2002**

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? \_\_\_\_\_

(e) While at work? \_\_\_\_\_ (Specify type of place) (c) Means of injury \_\_\_\_\_

23. Signature **W. S. May** (M. D. or N.M.D.)  
Address **Commissioner of Health** Date signed **12-29-47**

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

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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 *Henry M Brammer*

Licensed Embalmer No. *4200*

P. O. Address.....

**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.