

No. 3000
10-47
5-17-39

FILED OCT 16 1948
Registration District No. **114**

Primary Registration District No. **3012**

Registrar's No. **114**

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

1. PLACE OF DEATH:

(a) County CLAY

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

(c) Name of hospital or institution:
EXCELSIOR SPRINGS HOSPITAL
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 3 WEEKS
(Specify whether years, months or days)

In this community 37 YEARS
(Specify whether years, months or days)

3. (a) PRINT FULL NAME ELLA MAE PHILLIPS

3. (b) If veteran, name war NONE

3. (c) Social Security No. No

4. Sex FEMALE 5. Color or race WHITE

6. (a) Single, widowed, married, divorced WIDOWED

6. (b) Name of husband or wife ELMER D. PHILLIPS

6. (c) Age of husband or wife if alive deceased years

7. Birth date of deceased JANUARY 28 1912
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>76</u>	<u>6</u>	<u>26</u>	hr. min.

9. Birthplace UNKNOWN NEW YORK
(City, town, or county) (State or foreign country)

10. Usual occupation NURSING IN HOMES

11. Industry or business NONE

12. Name HENRY MILLER

13. Birthplace UNKNOWN NEW YORK
(City, town, or county) (State or foreign country)

14. Maiden name MARGARET UNKNOWN

15. Birthplace UNKNOWN NEW YORK
(City, town, or county) (State or foreign country)

16. (a) Informant Arthur S. Phillips

(b) Address #26 Daley, Excelsior Springs Mo

17. (a) BURIAL (b) Date thereof AUG. 25 1948
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation CROWN HILL

18. (a) Signature of funeral director Claude Dickard

(b) Address Excelsior Springs, Mo.

19. (a) 8/25/48 (b) Carroll Hutchings
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County CLAY **24**

(c) City or town EXCELSIOR SPRINGS **5**
(If outside city or town limits, write "RURAL")

(d) Street No. 724 KENNEDY STREET
(If rural, give location)

(e) Citizen of foreign country? NO (Yes or No)

If yes, name country -

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month AUGUST day 24
year 1948 hour 4 minute 30 A.M.

21. I hereby certify that I attended the deceased from 6-11 1948 to 8-24 1948
that I last saw her alive on 23 Aug 1948
and that death occurred on the date and hour stated above.

Immediate cause of death

<u>Uremia</u>	Duration <u>2 days</u>
<u>Pneumonia</u>	<u>3 days</u>

Due to Interoctant pneumonia

Due to 2 yr up.

Other conditions (Include pregnancy within 3 months of death)

Major findings:
- Of operations 186

Of autopsy 18

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

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 24

(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) (c) Means of injury 10

23. Signature [Signature] (M. D. or other) MD

Address Excelsior Springs Mo Date signed 8/25/48

RECEIVED

District Health Officer No. 3

District File Number _____

Date Filed 10-14-48

APR 6 1950

JUN 1 1949

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 Louise K. Jarman

Licensed Embalmer No. 4589

P. O. Address Excelsior Springs

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.

Registration District No. 71 Primary Registration District No. 3012

1. PLACE OF DEATH:

(a) County Clay
(b) City or town Excelsior Springs
(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)

3. (a) PRINT FULL NAME Ella Mae Phillipis

3. (b) If veteran, name war. _____ 3. (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 _____

7. Birth date of deceased Jan 2 1904
(Month) (Day) (Year)

8. AGE: Years 76 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) _____ (Burial, cremation, or removal) (b) Date thereof _____ (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (Date received local registrar) (b) _____ (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 _____ Day 24 Year 1948 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ to _____, 19____; that I last saw him/her 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) Accident

(b) Date of occurrence 8/1/48

(c) Where did injury occur Excelsior Springs, Clay, Mo. (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? Home

While at work _____ No. _____ (Specify type of place) (c) Means of injury Fall

23. Signature B. B. Robinson (M. D. or other) M. D.

Address 118 South St., Excelsior Springs, Mo. Date signed 11/9/48

SUPPLEMENTARY

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

S-32350