

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **5396**
 BIRTH NO. **FILED MAR 2 1954** REG. DIST. NO. **187** PRIMARY REG. DIST. NO. **3041** Registrar's No. **78**

1. PLACE OF DEATH a. COUNTY Livingston		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Livingston	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Chillicothe		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Chillicothe	
d. FULL NAME OF HOSPITAL OR INSTITUTION City Hospital		d. STREET ADDRESS (If rural, give location) 1214 Calhoun Street	
3. NAME OF DECEASED (Type or Print) a. (First) Cinda		c. (Last) Phillips	
b. (Middle) —		4. DATE OF DEATH (Month) (Day) (Year) February 23, 1954	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Never Married	8. DATE OF BIRTH February 22, 1954
9. AGE (In years last birthday) 12		10. KIND OF BUSINESS OR INDUSTRY Infant	
11. BIRTHPLACE (State or foreign country) Chillicothe, Missouri		12. CITIZEN OF WHAT COUNTRY? U.S.	
13a. FATHER'S NAME Bobbie W. Phillips		13b. MOTHER'S MAIDEN NAME Freida Ann Wagner	
14. NAME OF HUSBAND OR WIFE None		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	
16. SOCIAL SECURITY NO. None		17. INFORMANT'S SIGNATURE OR NAME AND ADDRESS B.W. Phillips: Chillicothe, Missouri	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) *This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Abortion, Cause Undetermined ANTECEDENT CAUSES (b) Causing premature miscarriage. Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (c) Infant to be delivered. II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION 776X	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT SUICIDE HOMICIDE (Specify)	
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR?		22. I hereby certify that I attended the deceased from 22 Feb, 1954 to 23 Feb, 1954 , that I last saw the deceased alive on 23 Feb, 1954 , and that death occurred at 1:15 Am. , from the causes and on the date stated above.	
23a. SIGNATURE (Degree or title) V. W. Vandiver M.D.		23b. ADDRESS Chillicothe Mo	
23c. DATE SIGNED 23 Feb 54		24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	
24b. DATE 2-24-54		24c. NAME OF CEMETERY OR CREMATORY Edgewood	
24d. LOCATION (City, town, or county) (State) Chillicothe Mo		25. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS Norman Funeral Home, Chillicothe, Mo.	
DATE REC'D BY LOCAL REG. 2-23-54		REGISTRAR'S SIGNATURE Frances B Neill	

(Licensed Embalmer's Statement on Reverse Side)

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

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 _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed *Edwin J. Norman*

Licensed Embalmer No. *4036*

P. O. Address *Chillicothe, 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.