

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **21716**

42911-55
FILED AUG 1-1955

BIRTH NO. _____ REG. DIST. NO. **116** PRIMARY REG. DIST. NO. **3020** Registrar's No. **126**

1. PLACE OF DEATH a. COUNTY Franklin		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Gasconade	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Washington		c. CITY OR TOWN Bland	d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION St. Francis Hosp.		e. STREET ADDRESS (If rural, give location) 03701	

3. NAME OF DECEASED (Type or Print) a. (First) Baby b. (Middle) Phelps c. (Last) Phelps			4. DATE OF DEATH (Month) (Day) (Year) July 23 1955		
5. SEX F	6. COLOR OR RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH July 22-1955	9. AGE (In years last birthday) 3	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
10a.		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTH PLACE (City and State or Foreign Country) Washington - Mo		12. CITIZEN OF WHAT COUNTRY? U.S.A.

13a. FATHER'S NAME Troy Phelps	13b. MOTHER'S MAIDEN NAME Zoe Campbell	14. NAME OF HUSBAND OR WIFE
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME Troy Phelps	ADDRESS Bland
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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, asthma, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH 3 min
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Prematurity		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) L DUE TO (c) L		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		776X	

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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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)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from birth, 19 to death, 19 , that I last saw the deceased alive on July 22 1955, and that death occurred at 11:30 m., from the causes and on the date stated above.

23a. SIGNATURE <i>[Signature]</i>	23b. ADDRESS <i>[Address]</i>	23c. DATE SIGNED 7-27-55
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24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE 7-24-55	24c. NAME OF CEMETERY OR CREMATORY Drove Dale Cemetery	24d. LOCATION (City, town, or county) (State) Marion County - Mo.
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DATE REC'D BY LOCAL REG. 7/29/55	REGISTRAR'S SIGNATURE <i>[Signature]</i>	99	FUNERAL DIRECTOR'S SIGNATURE <i>[Signature]</i>	ADDRESS <i>[Address]</i>
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(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.....
Signature of Student Embalmer

Signed.....

Licensed Embalmer No.....

P. O. Address.....

NOT Embalmed

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (If to comply with the above constitutes grounds for revocation of license).
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.