

FILED SEP 19 1956

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

30022

STATE FILE NUMBER

Registration District No. 47 Primary Registration District No. 3008 Registrar's No. 239

300
1-56

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

| | | | |
|---|--|--|---|
| 1. PLACE OF DEATH a. COUNTY <u>CALLAWAY</u> | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY <u>CLARK</u> | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) Inside Limits OR TOWN <u>FULTON, MISSOURI</u> Yes <input type="checkbox"/> No <input type="checkbox"/> | | c. CITY OR TOWN <u>WYA CONDA</u> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/> | |
| c. FULL NAME OF (If NOT in hospital, give location) Length of stay in lb HOSPITAL OR INSTITUTION <u>ST. HOSPITAL # 1</u> <u>109</u> DAYS | | d. STREET ADDRESS <u>NONE</u> (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>GEORGE WASHINGTON PHILLIPS</u> | | | 4. DATE OF DEATH Month Day Year <u>SEPT. 12 1956</u> |
| 5. SEX <u>MALE</u> | 6. COLOR OR RACE <u>WHITE</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>FEB. 15, 1873</u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>TRADER</u> | | 100. KIND OF BUSINESS OR INDUSTRY <u>CATTLE BUYER</u> | 9. AGE (In years last birthday) <u>83</u> IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. |
| 11. BIRTHPLACE (City and state or country) <u>MISSOURI</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>ABNER PHILLIPS</u> | | 14. MOTHER'S MAIDEN NAME <u>EDNA MAE CHILDERS</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u> | | 16. SOCIAL SECURITY NO. <u>NONE</u> | 17. INFORMANT <u>STATE HOSPITAL # 1, FULTON, MISSOURI</u> Address |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Decompensation</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <u>Hypertensive Cardiomegaly (710 gms)</u> DUE TO (c) <u>Cecum, adenocarcinoma</u> | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/> | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>153x</u> | | |
| 20c. TIME OF INJURY Hour Month, Day, Year a. m. p. m. | | | |
| 20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 20f. CITY, TOWN, OR LOCATION | COUNTY STATE |
| 21. <u>State Hospital # 1</u> attended the deceased from <u>10-23-54</u> to <u>9-12-56</u> and last saw <u>him</u> on <u>9-12-56</u> at <u>1:15 A. M.</u> on the date stated above; and to the best of my knowledge, from the causes stated. | | | |
| 22a. SIGNATURE <u>Frank J. Nichols</u> (By area or title) | | 22b. ADDRESS <u>STATE HOSPITAL # 1, FULTON, MO</u> | 22c. DATE SIGNED <u>9-12-56</u> |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE <u>Sept 14, 1956</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Fairmont</u> | 23d. LOCATION (City, town, or county) (State) <u>Fairmont 710.</u> |
| 24. FUNERAL DIRECTOR <u>Beth Sackett Wyaconda Mo</u> ADDRESS | 25. DATE RECD. BY LOCAL REG. <u>9/13/56</u> | 26. REGISTRAR'S SIGNATURE <u>Maretha Lawrence</u> | |

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 *Aector R. Masure*

Licensed Embalmer No. *49*

P. O. Address *Fulton,*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.