

**THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH**

State File No. **43675**
Registrar's No. **11173**

FILED DEC 27 1956

BIRTH NO. _____		REG. DIST. NO. 318		PRIMARY REG. DIST. NO. 1003		Registrar's No. 11173	
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY _____			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis				c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis			
d. FULL NAME OF HOSPITAL OR INSTITUTION Enroute to Homer G. Phillips				d. STREET ADDRESS (If rural, give location) 206 S. Garrison Ave.			
3. NAME OF DECEASED (Type or Print) a. (First) Ida		b. (Middle) Mae		c. (Last) Roberts Phillips		4. DATE OF DEATH (Month) (Day) (Year) Dec 3 1956	
5. SEX Female		6. COLOR OR RACE Negro		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married		8. DATE OF BIRTH November 8, 1920	
9. AGE (In years last birthday) 36		10. KIND OF BUSINESS OR INDUSTRY Housework		11. BIRTHPLACE (City and State or Foreign Country) Arkansas		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13a. FATHER'S NAME Millard Roberts		13b. MOTHER'S MAIDEN NAME Electra Harrold		14. NAME OF HUSBAND OR WIFE Marshall Phillips			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. unknown		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Millard Roberts - 206 S. Garrison Ave.			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) <i>*This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.</i>		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Lobar Pneumonia ANTECEDENT CAUSES <i>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.</i> DUE TO (b) _____ DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS <i>Conditions contributing to the death but not related to the disease or condition causing death.</i> 490 X				INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input checked="" 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 _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at 9:00Pm. , from the causes and on the date stated above.							
23a. SIGNATURE James M. Kelly Deputy Registrar				23b. ADDRESS 1300 Clark		23c. DATE SIGNED 12-5-56	
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal		24b. DATE 12-8-56		24c. NAME OF CEMETERY OR CREMATORY Greenwood Cemetery		24d. LOCATION (City, town, or county) (State) St. Louis County, Mo.	
DATE REC'D BY LOCAL REG. DEC 7 1956		REGISTRAR'S SIGNATURE J. C. Smith		25. FUNERAL DIRECTOR'S SIGNATURE Atkins Bros.		ADDRESS 3644 Finney Ave.	

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

3

1956
1912

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 James Craun

Licensed Embalmer No. 4755

P. O. Address 1771 N. Grand

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.