

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-008689

STATE FILE NUMBER

FILED MAR 18 1959

Registration District No. 59 Primary Registration District No. _____ Registrar's No. 51

5. 300
1-57

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1. PLACE OF DEATH a. COUNTY <u>CASS</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY <u>CASS</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Austin Township</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		c. CITY OR TOWN <u>Peculiar</u> ¹⁹⁰ Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>U.S. 714 Way</u> Length of stay in lb <u>None</u>		d. STREET ADDRESS (If outside, give location) <u>Peculiar</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED First Middle Last <u>PAUL HARRISON Phillips</u>			4. DATE OF DEATH Month Day Year <u>MARCH 7 1959</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>2-11-1937</u>
9. AGE (In years last birthday) <u>22</u>		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LABORER</u>		10b. KIND OF BUSINESS OR INDUSTRY _____	11. BIRTHPLACE (City and state or country) <u>KANSAS CITY, Missouri</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13a. FATHER'S NAME <u>PAUL HARRISON Phillips</u>	
13b. MOTHER'S MAIDEN NAME <u>LOLA WOODS</u>		14. NAME OF HUSBAND OR WIFE <u>Helen Phillips</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or service) <u>Yes 1955-1957</u>		16. SOCIAL SECURITY NO. <u>497-38-7783</u>	17. INFORMANT Address <u>Mrs Helen Phillips - Peculiar, Mo.</u>
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>Maximal cerebral fracture & aneurism of brain</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>None</u>			INTERVAL BETWEEN ONSET AND DEATH <u>0</u>
20a. ACCIDENT <input checked="" 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>Auto accident</u>	
20c. TIME OF INJURY Hour Month, Day, Year <u>9 3/7/59</u>		20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>Highway 91</u>		20f. CITY, TOWN, OR LOCATION <u>Archie</u>	COUNTY <u>Cass</u> STATE <u>Mo</u>
21. I attended the deceased from _____, to _____ and last saw her/him alive on _____ Death occurred at <u>9:00 P</u> m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>J. Taylor M.D.</u>		22b. ADDRESS <u>1400 East 5th Ave.</u>	22c. DATE SIGNED <u>3/7/59</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>3-10-59</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Crescent Hill Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>ADRAIN, MISSOURI</u>
24. FUNERAL DIRECTOR <u>Wm. D. Kelly</u>		25. DATE RECD. BY LOCAL REG. <u>3-15-59</u>	26. REGISTRAR'S SIGNATURE <u>Mrs. Ray Sebes</u>

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION

MAR 23 1959

VS JUN 29 1960

HEALTH DEPARTMENT

MAR 19 1959

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 *Robert Atkinson*

Licensed Embalmer No. *4902*

P. O. Address *.....*

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.