

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-011279

STATE FILE NUMBER

2 2409

REGISTRATION DISTRICT NO. _____ PRIMARY REGISTRATION DISTRICT NO. _____ REGISTRATION NO. _____

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN		c. CITY OR TOWN	
St. Louis		Madison	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION		d. STREET ADDRESS	
BARNES HOSPITAL		1640 3rd. St.	

3. NAME OF DECEASED (Type or print) First Middle Last Iera P. Phipps			4. DATE OF DEATH Month Day Year March 7 1959		
--	--	--	--	--	--

5. SEX Female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> / DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 10, 1889	9. AGE (In years last birthday) 69	10. UNDER 1 YEAR Months Days 2 27	11. UNDER 24 HRS. Hours Min. /
------------------	---------------------------	---	-----------------------------------	---------------------------------------	---	--------------------------------------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY at home	11. BIRTHPLACE (City and state or country) White County Illinois	12. CITIZEN OF WHAT COUNTRY? U.S.A.
--	--	---	--

13a. FATHER'S NAME Unknown	13b. MOTHER'S MAIDEN NAME Unknown	14. NAME OF HUSBAND OR WIFE Harrison Phipps
-------------------------------	--------------------------------------	--

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO	16. SOCIAL SECURITY NO. unknown	17. INFORMANT D. J. Phipps	Address Madison, Illinois
---	------------------------------------	-------------------------------	------------------------------

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>Pulmonary edema</u>		INTERVAL BETWEEN ONSET AND DEATH Abt. 4 hrs.
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Carcinoma of right lung</u> DUE TO (c) <u>163x</u>		
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.)
---	--

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. I attended the deceased from <u>March 5, 1959</u> to <u>March 7, 1959</u> and last saw her/him alive on <u>March 7, 1959</u> Death occurred at <u>8:25 P.M.</u> on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>FR Munday</u> (Degree or title) M.D.	22b. ADDRESS BARNES HOSPITAL	22c. DATE SIGNED 3/8/59
---	---------------------------------	----------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE March 8, 1959	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City, town, or county) (State) Madison, Illinois
--	----------------------------	------------------------------------	---

24. FUNERAL DIRECTOR <u>Francis J. Phipps</u> ADDRESS Madison, Illinois	25. DATE RECD. BY LOCAL REG. MAR 9 '59	26. REGISTRAR'S SIGNATURE <u>Loard Smith. M.D.</u>
--	---	---

(Licensed Embalmer's Statement on Reverse Side)

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

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

300
1-57
03
7I
00
DC

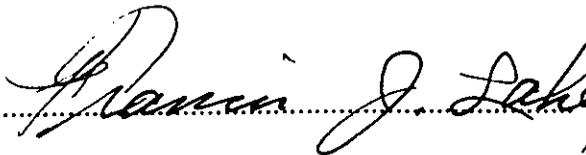
Health,
Welfare
Public
Service

FILED MAR 25 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 

Licensed Embalmer No. 2792.....

P. O. Address.....Madison, Illinois

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.