

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-017027  
STATE FILE NUMBER

FILED MAY 19 1959 Registration District No. 56 Primary Registration District No. 5195 Registrar's No. 6

300  
1-57

1. PLACE OF DEATH a. COUNTY <b>Carroll</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Carroll</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Prairie Twp.</b>		c. CITY OR TOWN <b>Norborne</b>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>7 Miles N.E. Norb</b>		Length of stay in lb <b>50 yrs.</b>	
3. NAME OF DECEASED (Type or print) First <b>Robert</b> Middle <b>Patterson</b> Last <b>Phillips</b>		4. DATE OF DEATH Month <b>May</b> Day <b>13</b> Year <b>1959</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 12, 1865</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farm</b>	11. BIRTHPLACE (City and state or country) <b>Adams County, Ohio</b>
13a. FATHER'S NAME <b>Thomas M. Phillips</b>		13b. MOTHER'S MAIDEN NAME <b>Eunice (unknown)</b>	14. NAME OF HUSBAND OR WIFE <b>Rosa Bell Osborn</b>
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>None</b>	17. INFORMANT Address <b>Robert N. Phillips Norborne, Mo.</b>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Valvular Heart Disease</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <b>Arteriosclerosis Diffuse</b> DUE TO (c) <b>Hypertension Essential</b>			INTERVAL BETWEEN ONSET AND DEATH <b>20+ years</b> <b>20+ years</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Hypertension Essential</b>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" 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 _____ a.m. _____ p.m. Month, Day, Year _____		20d. INJURY OCCURRED WHILE AT <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 <b>6-11-1941</b> , to <b>5-13-59</b> and last saw <sup>her</sup> him alive on <b>5-13-59</b> Death occurred at <b>9:45 p.m.</b> m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <b>Robert H. Kell MD</b>		22b. ADDRESS <b>212 South Pine St. Norborne, Mo.</b>	22c. DATE SIGNED <b>5-15-59</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>May 16, 1959</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Fairhaven Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>Norborne, Missouri</b>
24. FUNERAL DIRECTOR ADDRESS <b>Deitch Funeral Home Norborne, Mo.</b>		25. DATE RECD. BY LOCAL REG. <b>May 15, 1959</b>	26. REGISTRAR'S SIGNATURE <b>Eileen Pennington</b>

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
MEDICAL CERTIFICATION

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.

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 *Ben W. Gibson*

Licensed Embalmer No. *2961*  
P. O. Address *Carrollton*

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.