

Dept. Health,
 Soc., & Welfare
 J. S. Public
 Health Service

THE DIVISION OF HEALTH OF MISSOURI
 STANDARD CERTIFICATE OF DEATH

59-020277
 STATE FILE NUMBER

FILED JUN 29 1959 Registration District No. 1 Primary Registration District No. 3000 Registrar's No. 190

V. S. 300
 Rev. 1-57

1. PLACE OF DEATH a. COUNTY <u>Adair</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Macon</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Kirksville</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Anabel</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Laughlin Hosp.</u>		Length of stay in 1b <u>6 Days.</u>	d. STREET ADDRESS (If outside, give location) <u>R.R. Anabel</u> Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Katie</u> Middle <u>May</u> Last <u>Phillips</u>			4. DATE OF DEATH Month <u>June</u> Day <u>20</u> Year <u>1959</u>
5. SEX <u>Female</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>Sept. 11, 1882</u>
9. AGE (In years last birthday) <u>76</u>		IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u>	IF UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>no.</u>	11. BIRTHPLACE (City and state or country) <u>Macon County, Mo.</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13a. FATHER'S NAME <u>Chris Johns</u>	
13b. MOTHER'S MAIDEN NAME <u>Jane Perkins</u>		14. NAME OF HUSBAND OR WIFE <u>Willie Phillips</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>no.</u>	17. INFORMANT <u>Willie Phillips</u> Address <u>Anabel, 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>Coronary occlusion</u> DUE TO (b) <u>Coronary artery disease</u> DUE TO (c) <u>Generalized atherosclerosis</u>			INTERVAL BETWEEN ONSET AND DEATH <u>20 min</u> <u>unknown</u> <u>unknown</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Cholecystitis - Diabetes - Bacillary dysentery.</u>			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 <u> </u> Month <u> </u> Day <u> </u> Year <u> </u> a.m. <u> </u> p.m. <u> </u>		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 <u>June 15, 1959</u> to <u>June 20, 1959</u> and last saw her <u>alive</u> on <u>June 19, 1959</u> Death occurred at <u>hills</u> <u> </u> a.m. on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Deceased or title) <u>Jack Amthor</u>		22b. ADDRESS <u>Kirksville, Mo.</u>	22c. DATE SIGNED <u>6.22.59</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>June 22/59</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Woodville, Cem.</u>	23d. LOCATION (City, town, or county) (State) <u>Macon County, Mo.</u>
24. FUNERAL DIRECTOR <u>Lester Sutton</u> ADDRESS <u>Macon, Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>6-22-1959</u>	26. REGISTRAR'S SIGNATURE <u>Dana W. Ratliff</u>

The funeral director is responsible for the proper completion of this certificate. The medical certification in the specific manner required by 193.140 MoRS 1949. Securing the medical certification in the specific manner required by 193.140 MoRS 1949. No symptoms will be listed. 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.

MEDICAL CERTIFICATION
 USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
 JACK A. UXTER D.O.

1956 8 70r

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 *Charles L. Hutton*

Licensed Embalmer No. *4577*

P. O. Address... *Macon, Mo.*

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.