

R.I. DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS AUG 5 1959

59-027069

STATE FILE NUMBER

Registration District No. _____ Primary Registration District No. _____ Registrar's No. **2 6985**

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, give TOWNSHIP only) OR TOWN St. Louis		Length of stay in 1b 1 day	c. CITY OR TOWN St. Louis Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Deaconess Hospital		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 2734 McCausland Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Cecelia Middle NMI Last Phillips	4. DATE OF DEATH Month July Day 27th Year 1959
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5. SEX Female	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 7-31-1888	9. AGE (last birthday) 70	IF UNDER 1 YEAR Months Days	IF UNDER 24 HR Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY Own Home	11. BIRTHPLACE (City and state or country) Chicago, Ill.	12. CITIZEN OF WHAT COUNTRY USA
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13a. FATHER'S NAME Unknown	13b. MOTHER'S MAIDEN NAME Unknown	14. NAME OF HUSBAND OR WIFE Albert Phillips
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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. None	17. INFORMANT Frederick Phillips, 2711 Bremerton, Brentwood, Mo.
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) Peritonitis		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) Ruptured caecum	
	DUE TO (c) Carcinoma of transverse colon	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH (But not related to the terminal disease condition given in PART I (a))		PART III. If deceased was female was there a pregnancy in last 90 days. 153.1 <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown

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.)
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20c. TIME OF INJURY Hour _____ s.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
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21. I attended the deceased from **7-20-59** to **7-27-59** and last saw her alive on **7-27-59**
Death occurred at **12:15 PM** on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) Ernest H. Schoppe, M.D.	22b. ADDRESS 7200 Manchester	22c. DATE SIGNED 7-28-59
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23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 7-30-59	23c. NAME OF CEMETERY OR CREMATORY St. Peter's Cem.	23d. LOCATION (City, town, or county) (State) St. Louis Co. Mo.
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24. FUNERAL DIRECTOR JAY B. SMITH, Maplewood, Mo.	25. DATE RECD. BY LOCAL REG. JUL 28 59	26. REGISTRAR'S SIGNATURE Keal Smith, M.D.
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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

MS NOV 14 1968

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by _____, Student Embalmer No. _____ or by _____, Student Embalmer No. _____ working under my personal supervision.

Student _____
Signature of Student Embalmer _____

Signed _____

Licensed Embalmer No. 402

P. O. Address Maple

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to conform 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.