

MURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-036525

FILED VS NOV 4 1959

STATE FILE NUMBER

Registration District No. 146 Primary Registration District No. 3026 Registrar's No. 476

RENDERED

1. PLACE OF DEATH a. COUNTY <u>Jackson</u> b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Independence</u> Length of stay in 1b <u>1 month</u> c. FULL NAME OF (If not in hospital, give location) HOSPITAL OR INSTITUTION <u>Independence Sanitarium</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Jackson</u> c. CITY OR TOWN <u>Independence</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> d. STREET ADDRESS (If outside, give location) <u>1716 South Willow</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
---	--	---	--

3. NAME OF DECEASED (Type or print) First <u>Raymond</u> Middle <u>Phillips</u> Last <u>Phillips</u>			4. DATE OF DEATH Month <u>October</u> Day <u>25</u> Year <u>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>3-9-1894</u>	9. AGE (last birthday) <u>65</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>minister</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Assembly of God Church</u>		11. BIRTHPLACE (City and state or country) <u>Barnett, Mo</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13a. FATHER'S NAME <u>Shirley Phillips</u>		13b. MOTHER'S MAIDEN NAME <u>Rose Strong</u>		14. NAME OF HUSBAND OR WIFE <u>Eunice 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>490-24-1767</u>		17. INFORMANT Address <u>Mrs Eunice Phillips - 1716 So Willow Ind</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>Myo cardiac infarction acute</u> DUE TO (b) <u>Coronary atherosclerosis +</u> DUE TO (c) <u>cardiac decompensation</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 1/2 hrs</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		

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. <input type="checkbox"/> Yes <input 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.)		
20c. TIME OF INJURY Hour _____ a.m. _____ p.m. Month, Day, Year _____		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 10-22-59 to 10-25-59 and last saw her/him alive on 10-25-59
 Death occurred at 7:30 p m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <u>R. D. Labal MD</u>	22b. ADDRESS <u>Independence Mo</u>	22c. DATE SIGNED <u>10-26-59</u>
--	---	--

23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>Oct 29 1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Hopewell Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Hopewell Missouri</u>
24. FUNERAL DIRECTOR ADDRESS <u>Kilbuck Funeral Home 2315 Pinwood</u>		25. DATE RECD. BY LOCAL REG. <u>10-29-59</u>	26. REGISTRAR'S SIGNATURE <u>James H. Gray</u>

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

MS NOV 2 1959

W. Diehl
1210 South Oak
1130-5
El 27800

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

Chas E. Wicks

Licensed Embalmer No. *2644*

P. O. Address *Hemo*

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.