URI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

FILED VS SEP 29 1960

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 9196

STATE FILE NUMBER -60-036458

ENDED

1. PLACE OF DEATH
a. COUNTY
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: St. Louis — Length of stay in Hospital: 3 days
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: Cardinal Glennon Hosp. — Inside Limits: Yes ☒ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Illinois — b. COUNTY: St. Clair
c. CITY OR TOWN: East St. Louis, Ill. — Inside Limits: Yes ☐ No ☐
d. STREET ADDRESS (If outside, give location): 1453 Falling Springs — Reside on Farm: Yes ☐ No ☐

3. NAME OF DECEASED (Type or print): First: Theresa — Middle: — Last: Phillips
4. DATE OF DEATH: Month: Sept — Day: 17 — Year: 1960
5. SEX: Female
6. COLOR OR RACE: Negro
7. Married ☐ Never Married ☒ Widowed ☐ Divorced ☐
8. DATE OF BIRTH: 9/14/60
9. AGE (last birthday) — IF UNDER 1 YEAR: Months: — Days: 3 — IF UNDER 24 HR: Hours: — Min.:
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Infant
10b. KIND OF BUSINESS OR INDUSTRY: at home
11. BIRTHPLACE (City and state or country): St. Louis, Mo.
12. CITIZEN OF WHAT COUNTRY: USA
13a. FATHER'S NAME: Booker T. Phillips
13b. MOTHER'S MAIDEN NAME: Alberta Dell
14. NAME OF HUSBAND OR WIFE:
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: None
17. INFORMANT: Booker T.Phillips — Address: 1453 Falling Springs

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Congestive Heart Failure of Unknown Etiology — INTERVAL BETWEEN ONSET AND DEATH: 27 hrs.
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b)
DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a): 7730
PART III. If deceased was female was there a pregnancy in last 90 days. ☐ Yes ☐ No ☐ Unknown

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐
20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
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 ☐ NOT WHILE AT WORK ☐
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 September 15, to September 16 and last saw her alive on Sept. 16
Death occurred at 10 50 p.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): Marcella L. Cole, M.D.
22b. ADDRESS: Cardinal Glennon Hospital
22c. DATE SIGNED: 9/16

23a. BURIAL, CREMATION, REMOVAL (Specify): Removal
23b. DATE: 9/19/60
23c. NAME OF CEMETERY OR CREMATORY: Booker Washington
23d. LOCATION (City, town, or county) (State): East St. Louis, Illinois

24. FUNERAL DIRECTOR — ADDRESS: Marshall Funeral Home-E.St. Louis, Ill.
25. DATE RECD. BY LOCAL REG.: SEP 19 1960
26. REGISTRAR'S SIGNATURE: Earl Smith, M.D.

BY AFFIDAVIT OF

DOCUMENT

Anthony Jr. DR / 24 hrs

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by

or by _____, Student Embalmer No._____

working under my personal supervision.

Student_____ Signed Thomas M. Klobe

Signature of Student Embalmer

Licensed Embalmer No. 4479

P. O. Address 2205 Missouri East St. Louis

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