URI DIVISION OF HEALTH — STANDARD CERTIFICATE OF DEATH

-60-042631

STATE FILE NUMBER

T OF PUBLIC HEALTH AND WELFARE

Registration District No. 174 Primary Registration District No. 3035 Registrar's No. 110

ENDED FILED VS DEC 1 1960

1. PLACE OF DEATH
a. COUNTY Lafayette
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Lexington — Length of stay in 1b 13 Yr.
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location) Lexington Memorial Hospital — Inside Limits Yes ☒ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Missouri b. COUNTY Lafayette
c. CITY OR TOWN Lexington (rural) — Inside Limits Yes ☐ No ☒
d. STREET ADDRESS (If outside, give location) 5 Mi. S.W. of Lexington — Reside on Farm Yes ☒ No ☐

3. NAME OF DECEASED (Type or print) First Robert Middle L. Last Phillips
4. DATE OF DEATH Month November Day 10 Year 1960
5. SEX Male
6. COLOR OR RACE White
7. Married ☐ Never Married ☒ Widowed ☐ Divorced ☐
8. DATE OF BIRTH January 28, 1891
9. AGE (last birthday) 69 — 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) Farm Labor
10b. KIND OF BUSINESS OR INDUSTRY employee
11. BIRTHPLACE (City and state or country) Missouri
12. CITIZEN OF WHAT COUNTRY U.S.A
13a. FATHER'S NAME Robert C. Phillips
13b. MOTHER'S MAIDEN NAME Betty Maker
14. NAME OF HUSBAND OR WIFE None
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, not or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. None
17. INFORMANT Goodlee Rest Home Records, Address Rural Lexington, Mo.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebral thrombosis — INTERVAL BETWEEN ONSET AND DEATH 6 days
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b)
DUE TO (c) 332 X
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. ☐ 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 Nov. 4, 1960 to 11/10/60 and last saw her/him alive on 11-10-60
Death occurred at 6:00 A. m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) Joe N Ward M.D.
22b. ADDRESS Lexington Mo
22c. DATE SIGNED 11-22-60

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial
23b. DATE 11/12/60
23c. NAME OF CEMETERY OR CREMATORY Machpelah Cemetery
23d. LOCATION (City, town, or county) (State) Lexington Mo.

24. FUNERAL DIRECTOR Vaughn-Walker ADDRESS Lexington, Mo.
25. DATE RECD. BY LOCAL REG. 11-22-60
26. REGISTRAR'S SIGNATURE Minerva E Eastabrook

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

BY AFFIDAVIT OF

MEDICAL CERTIFICATION

STATEMENT BY LICENSED EMBALMER

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

or by _____, Student Embalmer No._____

working under my personal supervision.

Student_____ Signed Harold L Weal

Signature of Student Embalmer

Licensed Embalmer No. 45 8

P. O. Address Lexingto

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