

COURT DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-023035

AMENDED

Registration District No. _____

318

Primary Registration District No. _____

1003

Registrar's No. _____

5875

STATE FILE NUMBER

FILED JUN 29 1961

| | | | | | | | | | |
|--|--|---|--|---|---|--|--|-------------------------------------|--|
| 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 | | c. CITY OR TOWN St. Louis | | Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/> | | | |
| c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION D.O.A. Homer G. Phillips | | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | d. STREET ADDRESS (If outside, give location) 3669 Finney Ave nue | | Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/> | | |
| 3. NAME OF DECEASED (Type or print) First Thomas Middle Phillips Last Phillips | | | | 4. DATE OF DEATH Month 6 Day 19 Year 61 | | | | | |
| 5. SEX Male | | 6. COLOR OR RACE Colored | | 7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | | 8. DATE OF BIRTH 11-22-13 | | 9. AGE (last birthday) 47 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer | | | 10b. KIND OF BUSINESS OR INDUSTRY None | | 11. BIRTHPLACE (City and state or country) Louisiana | | 12. CITIZEN OF WHAT COUNTRY U.S.A. | | |
| 13a. FATHER'S NAME Thomas Phillips | | | 13b. MOTHER'S MAIDEN NAME Glaudie Gates | | | 14. NAME OF HUSBAND OR WIFE None | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Mrs. Herman J. Saul-130 O No Miro St. | | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion; DUE TO (b) Coronary Sclerosis. DUE TO (c) 420.1 Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| 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 _____ to _____ and last saw her/him alive on _____ Death occurred at _____ 1:45 p. m on the date stated above, and to the best of my knowledge, from the causes stated. | | | | | | | | | |
| 22a. SIGNATURE (Degree or title) Joseph M. Jones Deputy Cor | | | | 22b. ADDRESS 1300 Clark | | | 22c. DATE SIGNED 6-23-61 | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Removal | | 23b. DATE 6-25-61 | 23c. NAME OF CEMETERY OR CREMATORY Unknown | | | 23d. LOCATION (City, town, or county) (State) New Orleans, La. | | | |
| 24. FUNERAL DIRECTOR Ellis Funeral Home- 2820 Stoddard St. | | | | 25. DATE RECD. BY LOCAL REG. JUN 23 1961 | | 26. REGISTRAR'S SIGNATURE Robert Smith. M.D. | | | |

DATE AMENDED

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

ITEM NO. SHOULD READ

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 *William E. Culp*

Licensed Embalmer No. 4198

P. O. Address *St. Louis*

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.