

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=63-021144

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

STATE FILE NUMBER

Registration District No. 301 Primary Registration District No. _____ Registrar's No. 49

FILED JUN 3 1963

1. PLACE OF DEATH a. COUNTY <u>Ripley</u> b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Doniphan</u> Length of stay in 1b <u>4 days</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Carter</u> c. CITY OR TOWN <u>Grandin</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> d. STREET ADDRESS (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Ripley Co. Mem Hosp.</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		4. DATE OF DEATH <u>May 23, 1963</u> Month Day Year	

3. NAME OF DECEASED (Type or print) First Middle Last <p style="text-align: center; font-size: 18pt; font-weight: bold;">Alexander Clark Phillips</p>			4. DATE OF DEATH <u>May 23, 1963</u> Month Day Year			
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>7-17-78</u>	9. AGE (last birthday) <u>84</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>Retired Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>		11. BIRTHPLACE (City and state or country) <u>Izard Co., Arkansas</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
13a. FATHER'S NAME <u>William B. Phillips</u>		13b. MOTHER'S MAIDEN NAME <u>Elizabeth Hampton</u>		14. NAME OF HUSBAND OR WIFE <u>Rose Phillips</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of serv) <u>No</u>		16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>Mrs Rose Phillips Grandin, Mo.</u>		

18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> DUE TO (b) <u>Generalized arteriosclerosis</u> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (b), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u> <u>10 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			

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 him alive on 5/23/63
 Death occurred at 6:15 pm on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Deceased or title) <u>Frank Johnson M.D.</u>	22b. ADDRESS <u>Doniphan, Missouri</u>	22c. DATE SIGNED <u>5/25/63</u> (State)
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>5-26-63</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Pickren Hall Cemetery</u>	23d. LOCATION (City, town, or county) <u>Fulton Co. Arkansas</u>
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24. FUNERAL DIRECTOR ADDRESS <u>Edwards Funeral Home Doniphan, Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>5-25-63</u>	26. REGISTRAR'S SIGNATURE <u>Flora Broz</u>
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(Licensed Embalmer's Statement on Reverse Side)

DO NOT WRITE ON THIS STUB
 AMENDED
 DATE AMENDED
 0910
 201802
 3
 4 0
 5 1
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 7 1
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 94201
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 12 1-0
 13 1-0
 AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
 INSTEAD OF
 SHOULD READ
 ITEM NO.
 BY AFFIDAVIT OF
 DOCUMENT
 MEDICAL CERTIFICATION
 USE BLACK INK OR TYPEWRITER RIBBON

JUN 5 1963

1963 JUN 5 1963

Permit issued 5-25-63 J.B.

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 Gene A. Parent

Licensed Embalmer No. 4809

P. O. Address Nyer, Mo.

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.