

N. B. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

1 PLACE OF DEATH

County Darwin

Township White Pine

Inc. Town _____

City _____

STATE OF ARKANSAS
STATE BOARD OF HEALTH
Bureau of Vital Statistics
CERTIFICATE OF DEATH

File No. 4505

Registration District No. 38

Primary Registration District No. 5054

Registered No. _____

(No. _____ St.; _____ Ward)

2 FULL NAME Olan Phillips

If death occurred in a hospital or institution, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>male</u>	4. COLOR OR RACE <u>white</u>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <u>✓</u>
6. DATE OF BIRTH Month _____ Day _____ Year _____		
7. AGE <u>4</u> yrs. <u>0</u> mos. <u>0</u> ds.		If LESS than 1 day, _____ hrs. or _____ min?
8. OCCUPATION (a) Trade, profession, or particular kind of work <u>11-A</u> (b) General nature of industry, business, or establishment in which employed (or employer) <u>107A</u>		
9. BIRTHPLACE (State or Country) <u>Missouri</u>		
PARENTS	10. NAME OF FATHER <u>O Phillips</u>	
	11. BIRTHPLACE OF FATHER (State or Country) <u>Mo</u>	
	12. MAIDEN NAME OF MOTHER <u>Mo</u>	
	13. BIRTHPLACE OF MOTHER (State or Country) <u>Mo</u>	

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 2-16-1920
Month _____ Day _____ Year _____

17. I HEREBY CERTIFY That I attended the deceased from Feb 6, 1920, to Feb 16, 1920, that I last saw him alive on Feb 16, 1920, and that death occurred on the date stated above, at _____ m.

The CAUSE OF DEATH * was as follows:
Influenza

Duration _____ yrs. _____ mos. 10 ds.
Contributory Bronchopneumonia
SECONDARY

Duration _____ yrs. _____ mos. 7 ds.
Signed J. R. Reynolds M. D.
2/17, 1920 Address Grandview

*State the DISEASE CAUSING DEATH, or, in death from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)
At Place of death _____ yrs _____ mos _____ ds. In the State _____ yrs _____ mos _____ ds.

Where was disease contracted, if not at place of death?
Former or usual residence _____

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) A Phillips

(Address) Green 2720

15. Filed Mar 1 1920 M. H. Roberts REGISTRAR

19. PLACE OF BURIAL OR REMOVAL Worship Cemetery DATE OF REMOVAL Feb 17, 1920

20. UNDERTAKER H. C. Johnson ADDRESS Golden Mo

