

FILED AUG 19 1946 STANDARD CERTIFICATE OF DEATH

Registration District No. 348

Primary Registration District No. 45-10

1. PLACE OF DEATH:

(a) County Sullivan
 (b) City or town Osage
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: 1
 (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____ (Specify whether _____)

In this community Life
years, months or days3. (a) PRINT FULL NAME JESSE A. PHIPPS

3. (b) If veteran, name war ✓
 3. (c) Social Security No. ✓

4. Sex male 5. Color or race White
 6. (a) Single, widowed, married, divorced married

6. (b) Name of husband or wife Emma Phipps 6. (c) Age of husband or wife if alive 64 years7. Birth date of deceased: April 12 (Month) (Day) (Year)

8. AGE: Years 73 Months 3 Days 13 If less than one day
 hr. _____ min. _____

9. Birthplace Sullivan Co Mo (City, town, or county) (State or foreign country)10. Usual occupation Retired Farmer

11. Industry or business _____

12. Name Ambrose Phipps13. Birthplace Ill (City, town, or county) (State or foreign country)14. Maiden name Fannie Mills15. Birthplace va (City, town, or county) (State or foreign country)16. (a) Informant Vernon Phipps(b) Address Galt mo17. (a) burial (b) Date thereof 8-7-46
(Burial, cremation, or removal) (Month) (Day) (Year)(c) Place: burial or cremation Union Group18. (a) Signature of funeral director P. R. Payne(b) Address Galt mo19. (a) Aug 8-46 (b) Greta Caldwell
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Sullivan 105(c) City or town Osage 0
(If outside city or town limits, write "RURAL")

(d) Street No. _____ (If rural, give location) 0

(e) Citizen of foreign country? _____ (Yes or No)

If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 5
year 1946 hour 16 minute 35 P. M.21. I hereby certify that I attended the deceased from 4-7-46
1946 to 8-5 1946that I last saw him alive on 8/5 1946
and that death occurred on the date and hour stated above.Immediate cause of death Pneumonia Duration 5 daDue to acute prostatitis 3 mo

Due to _____

Other conditions _____
(Include pregnancy within 3 months of death)Major findings: _____
Of operations enlarged prostate

Of autopsy _____

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

(c) Where did injury occur? _____ (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place) (e) Means of injury 223. Signature J. W. ... (M. D. or other) _____Address Harris Mo Date signed 8/16/46

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

RECEIVED
District Health Officer No. 10
District File Number 8-46-1557
Dist. File AUG 4 1946

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.....

....., Registered Apprentice No.
working under my personal supervision.

Signed P. K. Payne Jr
Licensed Embalmer No. 3400
P. O. Address Galt

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 this body is not embalmed, fact should be so stated above.