

**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

Do not use this space.

1. PLACE OF DEATH

County Ray Registration District No. 744
Township _____ Primary Registration District No. 3035
City Richmond (No. _____ St. _____ Ward)

File No. 19025
Registered No. 44

2. FULL NAME

(a) Residence. No. _____ St. _____ Ward. _____
(Usual place of abode) (If nonresident, give city or town and State)

Length of residence in city or town where death occurred yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX _____ 4. COLOR OR RACE _____ 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)

Female White Married

5A. IF MARRIED, WIDOWED, OR DIVORCED
HUSBAND OF _____
(OR) WIFE OF M. R. Gibson

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Jan. 7 - 1899

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, _____ hrs. or _____ min.
32 4 6

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. House Duties
(b) General nature of industry, business, or establishment in which employed (or employer). _____
(c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) Aspen
(STATE OR COUNTRY) Colo.

10. NAME OF FATHER George Phillips

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Not known
(STATE OR COUNTRY) Austria

12. MAIDEN NAME OF MOTHER Anna Marovitch

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Not known
(STATE OR COUNTRY) Austria

14. INFORMANT M. R. Gibson
(Address) Richmond Mo

15. FILED 5-8-31 E. E. Gay REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) May 6 - 1931

17. I HEREBY CERTIFY, That I attended deceased from 4/24, 1931, to 5-6, 1931, that I last saw h. _____ alive on _____, 19____, and that death occurred, on the date stated above, at 1-a m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

131 Chronic Nephritis
97 (duration) yrs. 8 mos. _____ ds.

CONTRIBUTORY (SECONDARY) arteriosclerosis
(duration) yrs. _____ mos. _____ ds.

18. WHERE WAS DISEASE CONTRACTED
131
IF NOT AT PLACE OF DEATH _____

DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____

WAS THERE AN AUTOPSY? no (1)

WHAT TEST CONFIRMED DIAGNOSIS _____

(Signed) E. T. Myer, M. D.

, 19____ (Address) Richmond Mo

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) Whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL _____ DATE OF BURIAL _____

City Cemetery May 8, 1931

20. UNDERTAKER E. Thurman ADDRESS Richmond

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.

MAY 27 1931

