

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

Do not use this space.

24328

**1. PLACE OF DEATH**

County Jackson  
 Township Flour  
 City Kansas City

Registration District No. 399

File No. 3015  
 Registered No. 3015  
 St. 3 Ward

Primary Registration District No. 1002

**2. FULL NAME**

Jackie Phleps  
 (a) Residence No. 524 E 15 St. 2 Ward.

(Usual place of abode) (If nonresident give city or town and State)  
 Length of residence in city or town where death occurred 3 yrs. mos. 2 ds. How long in U.S., if of foreign birth? yrs. mos. ds.

**PERSONAL AND STATISTICAL PARTICULARS**

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

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OR (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Nov 22 1927

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.  
3 8 16

**8. OCCUPATION OF DECEASED**

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

9. BIRTHPLACE (CITY OR TOWN) Hallen Mo.  
 (STATE OR COUNTRY)

10. NAME OF FATHER Dwight Phleps

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Mo  
 (STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER Killie Curtney

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Mo  
 (STATE OR COUNTRY)

14. INFORMANT Dwight Phleps  
 (Address) 524 E 15 St

15. FILED 8/9 1927 M. M. Crowe REGISTRAR  
Asst

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) 8/8 19 27

17. I HEREBY CERTIFY, That I attended deceased from ..... 19....., to ..... 19..... that I last saw h..... alive on..... 19....., and that death occurred, on the date stated above, at 11:50 a.m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:  
Auto-truck, Traumatism  
multiple injuries  
2/10/14 (duration)..... yrs..... mos..... ds.

CONTRIBUTORY (SECONDARY) In Kansas City (duration)..... yrs..... mos..... ds.

18. WHERE WAS DISEASE CONTRACTED? 8/8/27  
 IF NOT AT PLACE OF BIRTH.....

19. DID AN OPERATION PRECEDE DEATH..... DATE OF.....

20. WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? Inspection  
 (Signed) H.E. Mason, M. D.

8/8, 19 27 (Address) Corcoran

\*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 Denton Mo DATE OF BURIAL Aug 10 1927

20. UNDERTAKER Mrs. C. L. Fauter ADDRESS Kansas City

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.

586

