

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

Do not use this space.

16360  
2268

**1. PLACE OF DEATH**

County Jackson  
Township Jackson  
City Kansas City (No. 1524 Olive)

Registration District No. 399  
Primary Registration District No. 1002

File No. \_\_\_\_\_  
Registered No. \_\_\_\_\_  
St. \_\_\_\_\_ Ward \_\_\_\_\_

**2. FULL NAME**

Alice Louise Phillips  
(a) Residence. No. 1524 Olive St. (11) Ward \_\_\_\_\_

(If nonresident, give city or town and State)

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

**PERSONAL AND STATISTICAL PARTICULARS**

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

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Oct. 10, 1929

7. AGE YEARS MONTHS DAYS If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.  
7 17

**8. OCCUPATION OF DECEASED**

(a) Trade, profession, or particular kind of work None  
(b) General nature of industry, business, or establishment in which employed (or employer) \_\_\_\_\_  
(c) Name of employer \_\_\_\_\_

9. BIRTHPLACE (CITY OR TOWN) Detroit (STATE OR COUNTRY) Michigan

10. NAME OF FATHER John Phillips

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Texas (STATE OR COUNTRY) \_\_\_\_\_

12. MAIDEN NAME OF MOTHER Lucille Rivers

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Arkansas (STATE OR COUNTRY) \_\_\_\_\_

14. INFORMANT Lucille Phillips (Address) 1524 Olive

15. FILED 8/14 30 1930 M.M. Crowe REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

2 **16. DATE OF DEATH (MONTH, DAY AND YEAR)** 5/27 1930

17. I HEREBY CERTIFY, That I attended deceased from 5/21/30 1930 to 5/27/30 1930, and that I last saw him alive on 5/27/30 1930, and that death occurred, on the date stated above, at 6:25 a.m.

THE CAUSE OF DEATH WAS AS FOLLOWS:  
Acute Bronchopneumonia  
Acute Bronchopneumonia  
107A  
194B

(duration) \_\_\_\_\_ yrs. mos. ds.  
CONTRIBUTORY (SECONDARY) Exposure  
(duration) \_\_\_\_\_ yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED Home  
IF NOT AT PLACE OF DEATH \_\_\_\_\_

DID AN OPERATION PRECEDE DEATH? \_\_\_\_\_ DATE OF \_\_\_\_\_

WAS THERE AN AUTOPSY? \_\_\_\_\_

WHAT TEST CONFIRMED DIAGNOSIS? Winged  
(Signed) Henry B. Carson M. D.  
5/27 1930 (Address) 1524 Olive

\*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 Northland Cemetery DATE OF BURIAL 5 29, 1930

20. UNDERTAKER Hatkins Bros. ADDRESS 1729 Lydia

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.

Lyonne.