

Registration District No. 399

Primary Registration District No. 1002

Registrar's No. 1927

1. PLACE OF DEATH:

(a) County Jackson  
(b) City or town Kansas City  
(c) Name of hospital or institution: 2023 Spruce  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 25 Yrs  
(Specify whether years, months or days)

3. (a) PRINT FULL NAME Lawson F. Phillips

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

4. Sex Male 5. Color or race Wh. 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Nellie M. Phillips 6. (c) Age of husband or wife if alive 58 years

7. Birth date of deceased June 18 1878  
(Month) (Day) (Year)

8. AGE: Years 68 Months 6 Days 9 If less than one day hr. min.

9. Birthplace Sarcoxis Mo.  
(City, town, or county) (State or foreign country)

10. Usual occupation Unemployed

11. Industry or business No

12. Name Philip Phillips

13. Birthplace Unknown Ill.  
(City, town, or county) (State or foreign country)

14. Maiden name Sarah Keith

15. Birthplace Carthage Mo.  
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature [Signature]

(b) Address 2023 Spruce St. Mo.

17. (a) Burial (b) Date thereof Dec. 29 39  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Forest Hill

18. (a) Signature of funeral director [Signature]

(b) Address 1800 Linwood K.C. Mo.

19. (a) Dec 29, 1939 (b) [Signature]  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Jackson  
(c) City or town Kansas City  
(If outside city or town limits, write "RURAL")  
(d) Street No. 2023 Spruce  
(If rural, give location)  
(e) If foreign born, how long in U. S. A. \_\_\_\_\_ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 12 day 27 year 39  
hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from 11:30 a.  
\_\_\_\_\_ 19\_\_\_\_, to \_\_\_\_\_ 19\_\_\_\_;  
the deceased \_\_\_\_\_ alive on \_\_\_\_\_ 19\_\_\_\_;  
and that death occurred on the date and hour stated above.

Immediate cause of death Acute pulmonary congestion  
acute coronary occlusion (MI)  
Coronary sclerosis  
Due to 23

Other conditions 0  
Significant pregnancy within 3 months of death 0  
Major findings: Acute pulmonary coronary tuberculosis  
Of operations \_\_\_\_\_

Of autopsy [Signature]

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)  
Means of injury \_\_\_\_\_

23. Signature [Signature] (M. D. or other) \_\_\_\_\_  
Address K.C. Mo. Date signed \_\_\_\_\_

Duration \_\_\_\_\_  
Underline the cause to which death should be charged statistically

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

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.

---

---

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 Chas Wilks

Licensed Embalmer No. 2644

P. O. Address 1800 Linwood

**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, above space should be left blank.**