

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

1. PLACE OF DEATH:

(a) County Jackson
(b) City or town Kansas City
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Trinity Lutheran Hospital
(If not in hospital or institution, write street number or location) 1 Mo.
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community Non-Resident
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Kansas (b) County Wyandotte
(c) City or town Kansas City
(If outside city or town limits, write "RURAL")
(d) Street No. 4449 Adams Street
(If rural, give location)
(e) If foreign born, how long in U. S. A. ? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 10
year 1940 hour 2 minute 45th A.M.
21. I hereby certify that I attended the deceased from May 5, 40
to June 12, 1940
that I last saw him alive on June 9th, 1940,
and that death occurred on the date and hour stated above.

Immediate cause of death:
1-Coronary thrombosis.
2-Pulmonary thrombosis. 10 days
Due to 3-Pneumonia. about 2 wks.
4-Old hypertension
Due to 5-Generalized anasarca.
Other conditions _____
(Include pregnancy within 3 months of death)

Duration
Physician
Underline the cause to which death should be charged statistically.

Major findings:
Of operations _____
Of autopsy yes

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)
(c) Means of injury 1

23. Signature W. B. T. Smith (M. D. or other)
Address 1001 1/2 Franklin Date signed 6-10-40

3. (a) PRINT FULL NAME Louis B. Phillips 412

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

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

6. (b) Name of husband or wife Sarah Phillips 6. (c) Age of husband or wife if alive 30 years

7. Birth date of deceased September 29 1903
(Month) (Day) (Year)

8. AGE: Years 36 Months 8 Days 12 If less than one day
hr. _____ min. _____

9. Birthplace Topeka Kansas
(City, town, or county) (State or foreign country)

10. Usual occupation Butcher & grocery store owner

11. Industry or business _____

12. Name Arthur J. Phillips

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

14. Maiden name Margaret J. Hughes

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

16. (a) Informant Mrs. Sarah Phillips
(b) Address 4449 Adams St.--K.C.K.

17. (a) burial (b) Date thereof 6-12-40
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Mt. Moriah Cemetery

18. (a) Signature of funeral director State Funeral Home
(b) Address Kansas City, Kansas

19. (a) June 10, 1940 (b) M. M. Crowe
(Date received local registrar) (Registrar's signature)

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

MOTHER FATHER

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 Mary L. Gates

Licensed Embalmer No. 245

P. O. Address 1901 Olath Blvd.

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.

RURAL JUL 15 1940

MISSOURI STATE BOARD OF HEALTH
DEPARTMENT OF COMMERCE
STANDARD CERTIFICATE OF DEATH

State File No.

Registration District No.

Primary Registration District No.

Registrar's No. 2372

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

1. PLACE OF DEATH:

(a) County.....
(b) City or town.....
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
.....
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution.....
In this community..... (Specify whether
years, months or days)

3. (a) PRINT FULL NAME Arrous B Phillipa

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

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

6. (b) Name of husband or wife..... 6. (c) Age of husband, or wife, if alive..... year.....

7. Birth date of deceased (Month) (Day) (Year)

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

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

10. Usual occupation.....

11. Industry or business.....

12. Name.....

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

14. Maiden name.....

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

16. (a) Informant.....

(b) Address.....

17. (a)..... (b) Date thereof..... (Month) (Day) (Year)

(c) Place: burial or cremation.....

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

(b) Address.....

19. (a)..... (b)..... (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 6 day 10
year 1940 hour..... minute..... M.

21. I hereby certify that I attended the deceased from....., 19....., to....., 19.....;
that I last saw h..... alive on....., 19.....;
and that death occurred on the date and hour stated above.

Immediate cause of death.....
3 thrombosis
4 pulmonary thrombosis
5 pneumonia lobar
6 old myeloclerosis
7 generalized anaemia

Other conditions..... (include pregnancy within 3 months of death) 108

Major findings: Of operations.....

Of autopsy.....

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?

..... (Specify type of place)

While at work?..... (e) Means of injury.....

23. Signature..... (M. D. or other).....

Address..... Date signed.....

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

SUPPLEMENTARY

S-20755