

No. 2  
1-13-40  
-17-39  
X23159

Registration District No. 397 Primary Registration District No. 1002

48  
3  
8  
WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

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)  
(d) Length of stay: In hospital or institution \_\_\_\_\_  
(Specify whether \_\_\_\_\_)  
In this community 36 years  
years, months or days

3. (a) PRINT FULL NAME Mrs. Angie May Harris

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

4. Sex Female 5. Color or race White  
6. (a) Single, widowed, married, divorced Married  
6. (b) Name of husband or wife James Scott Harris  
6. (c) Age of husband or wife if alive 60 years  
7. Birth date of deceased November 14 1886  
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>54</u>	<u>4</u>	<u>1</u>	_____ hr. _____ min.

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

10. Usual occupation Housewife

11. Industry or business ---

MOTHER FATHER  
12. Name John Henry Phillips  
13. Birthplace U.S.A.  
(City, town, or county) (State or foreign country)  
14. Maiden name Sarah Jane Gough  
15. Birthplace U.S.A.  
(City, town, or county) (State or foreign country)

16. (a) Informant James Scott Harris

(b) Address 4750 Hudson Road, Jo. Co. Kan.

17. (a) Removal (b) Date thereof 3/18/41  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Bellevue, Missouri

18. (a) Signature of funeral director Walter Teuneral Home

(b) Address Kansas City, Kansas

19. (a) 3/12/1941 (b) M. M. Crown  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED: 48  
(a) State Kansas (b) County Johnson  
(c) City or town Rural  
(If outside city or town limits, write "RURAL")  
(d) Street No. 4750 Hudson Road  
(If rural, give location) /  
(e) If foreign born, how long in U. S. A.? \_\_\_\_\_ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 15,  
year 1941 hour 8 minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from Feb 1, 1941  
19\_\_\_\_ to March 15, 1941  
that I last saw her alive on March 15, 1941  
and that death occurred on the date and hour stated above.

Immediate cause of death Gastric Neurotoxic  
570 cch

Due to Splenomegaly  
5 yrs.

Due to Venus hypertension  
Calcified Arteries  
Sclerotic Artery

Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_  
Major findings: \_\_\_\_\_  
Of operations 75/10

Of autopsy same 75/12

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

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. B. Casbolt MD  
329 Welpe Ave R.E. No. 10 (M.D. or other) \_\_\_\_\_  
Date signed 3-17-41

**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 *L Ross Blanford*

Licensed Embalmer No. *4015*

P. O. Address *41<sup>st</sup> + State Line*

**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, fact should be so stated above.**