

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. **24207**

FILED AUG 10 1941  
Registration District No. **11**

Primary Registration District No. **1002**

Registrar's No. **2746**

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: **K.C. General Hospital No. 1**  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution **Few seconds**  
(Specify whether  
In this community **0**  
years, months or days)

3. (a) PRINT FULL NAME **Corp, Phillip Dale**  
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 **Single**  
6. (b) Name of husband or wife. 6. (c) Age of husband or wife if alive. years  
7. Birth date of deceased **July 15th 1941**  
(Month) (Day) (Year)

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

9. Birthplace **K.C. Mo.**  
(City, town, or county) (State or foreign country)

10. Usual occupation

11. Industry or business

MOTHER FATHER { 12. Name **Pete Phillips**  
13. Birthplace **Unknown**  
(City, town, or county) (State or foreign country)  
14. Maiden name **Opal Thorp**  
15. Birthplace **Little River Kansas**  
(City, town, or county) (State or foreign country)

16. (a) Informant **Record Clerk**

(b) Address **K.C. General Hospital**

17. (a) **Burial** (b) Date thereof **7-23-41**  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **buried**

18. (a) Signature of funeral director **Wm. G. Bohmeyer**

(b) Address **17 C. Sun Dept.**

19. (a) **7-22-41** (b) **M. M. Crow**  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Jackson**  
(c) City or town **Kansas City**  
(If outside city or town limits, write "RURAL")  
(d) Street No. **K. 321 W. 51st St. Terrace**  
(If rural, give location)  
(e) Citizen of foreign country? (Yes or No) **0**  
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **July** day **15th**  
year **1941** hour **11** minute **17 P.** M.

21. I hereby certify that I attended the deceased from **7-15-41** to **7-15-41**  
that I last saw him alive on **7-15-41**  
and that death occurred on the date and hour stated above.

Immediate cause of death. **Intracranial hemorrhage**  
Due to.....  
Due to..... **1600**  
Other conditions. **1600**  
(Include pregnancy within 3 months of death)

Major findings: **Of operations**  
Of autopsy. **See above**

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) (e) Means of injury.....  
23. Signature **Wm. G. Bohmeyer** (M. D. or other) **0**  
Address **Dir. K.C. Gen. Hospital** Date signed.....

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

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**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.....

Licensed Embalmer No.....

P. O. Address.....

**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.**