

FILED OCT 13 1941

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No.

30746

3503

Registration District No. 399

Primary Registration District No. 1002

Registrar's No.

1. PLACE OF DEATH:

(a) County Jackson
(b) City or town Kansas City, Mo.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: St. Joseph's Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 19 days
(Specify whether
In this community non-resident
years, months or days)

3. (a) PRINT FULL NAME Phillips, Mrs. Tine E. (Co.)

3. (b) If veteran, name war. _____ 3. (c) Social Security No. None

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

6. (b) Name of husband or wife Tine Phillips 6. (c) Age of husband or wife if alive 55 years

7. Birth date of deceased August 14, 1888
(Month) (Day) (Year)

8. AGE: Years 53 Months 1 Days 4 If less than one day hr. _____ min. _____

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

10. Usual occupation Housewife

11. Industry or business _____

12. Name Henry Burkhardt

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

14. Maiden name Charlotte Knight

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

16. (a) Informant Tine Phillips

(b) Address Wellsville, Kansas

17. (a) Removal to _____ (b) Date thereof Sept 18, '41
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Wellsville Kansas

18. (a) Signature of funeral director Don Coughlin

(b) Address Wellsville, Kansas

19. (a) 9/20/41 (b) M. M. Crowe
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Kansas (b) County 999
(c) City or town Wellsville?, Kansas 14
(If outside city or town limits, write "RURAL") 0
(d) Street No. _____ (If rural, give location)
(e) If foreign born, how long in U. S. A.? 2 years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 18
year 1941 hour 7 minute 30 p.m.

21. I hereby certify that I attended the deceased from 9-21, 1941, to 9-18, 1941;
that I last saw him alive on 9-18, 1941;
and that death occurred on the date and hour stated above.

Immediate cause of death: Non-malignant tubercoid uterus

Due to _____
Due to 5/10/15 5/6
Other conditions (Include pregnancy within 3 months of death) _____

Major findings: Hysterectomy - 9/4/41
Of operation _____
Of autopsy Pulmonary thrombotic embolus - post-operative

Duration

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? _____

While at work? _____ (Specify type of place) (e) Means of injury _____
23. Signature Edw. A. Samuelson (M. D. or other) 0
Address St. Joseph's Hospital Date signed 9-18-41

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

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 *Orville H. Beckwith*

Licensed Embalmer No. *3937*

P. O. Address *Kansas City, Kans*

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.