

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

30774
4063

State File No.

FILED SEP 24 1954

BIRTH NO. _____ REG. DIST. NO. 149 PRIMARY REG. DIST. NO. 1002 Registrar's No. _____

1. PLACE OF DEATH a. COUNTY <u>JACKSON</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>MISSOURI</u> b. COUNTY <u>JACKSON</u>	
b. CITY (If outside corporate limits, write RURAL and give town(ship)) <u>KANSAS CITY</u>	c. LENGTH OF STAY (In this place) <u>42 YEARS</u>	c. CITY OR TOWN <u>KANSAS CITY</u>	d. Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>3940 N. GEE STREET, CONN.</u>		STREET ADDRESS (If rural, give location) <u>2757 HOLMES STREET</u>	

3. NAME OF DECEASED (Type or Print) <u>LILLY E. PHIFER</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>AUGUST 19, 1954</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>WIDOWED 2</u>	8. DATE OF BIRTH <u>DEC. 18, 1897</u>
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>AT HOME</u>	9. AGE (In years last birthday) Months Days Hours Mins. <u>56</u>
11. BIRTHPLACE (City and State or Foreign Country) <u>COLOGNE, GERMANY</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	

13a. FATHER'S NAME <u>LEO HALLBERG</u>	13b. MOTHER'S MAIDEN NAME <u>ELIZABETH URBAN</u>	14. NAME OF HUSBAND OR WIFE <u>Walter Phifer</u>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>	16. SOCIAL SECURITY NO. <u>495-07-8809</u>	17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>MRS. STEPHANIE H. KRAUSE 518 Argyle Bldg. Kansas City, Missouri</u>

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebral Hemorrhage</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 1/2 hrs.</u>
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Previous cerebral Hemorrhage</u>		<u>2 hrs.</u>
	II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Semility with Arteriosclerosis</u>		<u>33 1/2</u>

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 10 Aug, 1954 to 19 Aug, 1954, that I last saw the deceased alive on 18 Aug, 1954 and that death occurred at 6:45 P.M., from the causes and on the date stated above.

23a. SIGNATURE <u>Wallace H. Graham, M.D.</u>	(Degree or title)	23b. ADDRESS <u>518 Argyle Bldg.</u>	23c. DATE SIGNED <u>20 Aug '54</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>CREMATION</u>	24b. DATE <u>AUG. 23, 1954</u>	24c. NAME OF CEMETERY OR CREMATORY <u>D.W. NEWCOMER'S SONS CREMATION</u>	24d. LOCATION (City, town, or county) (State) <u>KANSAS CITY, MISSOURI</u>
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DATE REC'D BY LOCAL REG. <u>8-23-54</u>	REGISTRAR'S SIGNATURE <u>Geraldine Smith</u>	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>H. W. Newcomer's Sons 1331 Bross Creek Kansas City, Missouri</u>
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD
Wallace H. Graham

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, Student Embalmer No. working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed *Robert J. Boyer*

Licensed Embalmer No. *489*

P. O. Address *K.C. 10, Mo.*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.