

Health,  
& Welfare  
Public  
Service

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-044570

FILED JAN 5 1959

STATE FILE NUMBER

Registration District No. 150 Primary Registration District No. 5572 Registrar's No. 283

S. 300  
1-57

1. PLACE OF DEATH a. COUNTY <b>Jackson</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Jackson</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Rural Prairie Prairie</b>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	c. CITY OR TOWN <b>Kansas City</b>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Jackson Co Hospital</b>		Length of stay in 1b <b>1 day</b>	d. STREET ADDRESS (If outside, give location) <b>8630 E Alice</b>
3. NAME OF DECEASED (Type or print) First <b>JULIA</b> Middle <b>MAY</b> Last <b>PHILLIPS</b>			4. DATE OF DEATH Month <b>December</b> Day <b>25</b> Year <b>1958</b>
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> 2 DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 13 1908</b>
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		9b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years at birthday) <b>50</b> FUNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <b>Carthage Missouri</b>
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13a. FATHER'S NAME <b>Spencer</b>	
13b. MOTHER'S MAIDEN NAME <b>No Record</b>		14. NAME OF HUSBAND OR WIFE <b>James A Phillips (Dec)</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	17. INFORMANT Address <b>Mr Leonard R Frey 8630 E Alice K C Mo.</b>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Asphyxia and Circulatory Failure</b> DUE TO (b) <b>Asthma and Cardiac Decompensation</b> DUE TO (c) <b>Bilateral Bronchopneumonia</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Obesity and Recent inhaled irritant</b>			INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)		
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.	20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION COUNTY STATE		
21. I attended the deceased from <b>June 1957</b> to <b>Dec 23-58</b> and last saw her <sup>him</sup> alive on <b>12-23-58</b> Death occurred at <b>12-25-58 1:00</b> m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <b>M.C. Coakley Do.</b> (Degree or title)		22b. ADDRESS <b>6235 Truman Rd</b>	
22c. DATE SIGNED <b>12/26/58</b>		23a. NAME OF CEMETERY OR CREMATORY <b>Mt Washington Cemetery</b>	
23b. DATE <b>12/27/58</b>		23d. LOCATION (City, town, or county) (State) <b>Kansas City Missouri</b>	
23c. BURIAL, CREMATION, REMOVAL, (Specify) <b>Burial</b>		24. FUNERAL DIRECTOR <b>Sheil Funeral Home Kansas City Mo.</b>	
24. FUNERAL DIRECTOR ADDRESS		25. DATE RECD. BY LOCAL REG. <b>12-21-1958</b>	
25. DATE RECD. BY LOCAL REG.		26. REGISTRAR'S SIGNATURE <b>M.B. Longford</b>	

All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

6561 6  
JAN 6 1959

**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 *Thomas A. Shel* .....

Licensed Embalmer No. *4934* .....  
P. O. Address *X.C.M.D.* .....

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.