

# DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-029264

FILED VS SEP 4 1959

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Registration District No. 1002 Primary Registration District No. 1002 Registrar's No. 4016 STATE FILE NUMBER

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Jackson</b> b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Kansas City</b> Length of stay in 1b <b>18 days</b> c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>VA Hospital, K. C. Mo.</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <b>Kansas</b> b. COUNTY <b>Johnson</b> c. CITY OR TOWN <b>Kansas City</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> d. STREET ADDRESS (If outside, give location) <b>1818 North 30th St.</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
<b>3. NAME OF DECEASED</b> (Type or print) First <b>CLIFFORD</b> Middle <b>ALLEN</b> Last <b>PHILO</b>		<b>4. DATE OF DEATH</b> Month <b>August</b> Day <b>15th</b> Year <b>1959</b>			
<b>5. SEX</b> <b>Male</b>	<b>6. COLOR OR RACE</b> <b>White</b>	<b>7. Married</b> <input checked="" type="checkbox"/> <b>Never Married</b> <input type="checkbox"/> <b>Widowed</b> <input type="checkbox"/> <b>Divorced</b> <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <b>6/27/91</b>	<b>9. AGE (last birthday)</b> <b>68</b>	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Civil Engineer</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Wadena, Minnesota</b>		<b>11. BIRTHPLACE</b> (City and state or country) <b>US.A.</b>	
<b>13a. FATHER'S NAME</b> <b>W. W. Philo</b>		<b>13b. MOTHER'S MAIDEN NAME</b> <b>Ellen Cameron</b>		<b>14. NAME OF HUSBAND OR WIFE</b> <b>Helen Philo</b>	
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or dates of service) <b>Yes WWI</b>		<b>16. SOCIAL SECURITY NO.</b> <b>498-24-0147</b>		<b>17. INFORMANT</b> Address <b>VA HOSPITAL OFFICIAL RECORDS, K. C. MO.</b>	
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Shock</b> DUE TO (b) <b>Unknown cause, possible cerebral vascular accident</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (c) _____				INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)				PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	<b>20a. ACCIDENT SUICIDE HOMICIDE</b> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in PART I or PART II of item 18.)		
<b>20c. TIME OF INJURY</b> Hour _____ a.m. _____ p.m. Month, Day, Year _____		<b>20d. INJURY OCCURRED WHILE AT WORK</b> <input type="checkbox"/> <b>NOT WHILE AT WORK</b> <input checked="" type="checkbox"/>			
<b>20e. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)		<b>20f. CITY, TOWN, OR LOCATION</b> COUNTY STATE			
<b>21. VA attended the deceased from</b> <u>7-29-59</u> to <u>8-15-59</u> and last saw him <u>7:35 a.m.</u> on the date stated above, and to the best of my knowledge, from the causes stated. Death occurred at <u>7:35 a.m.</u>					
<b>22a. SIGNATURE</b> (Degree or title) <b>Albert L. Chason</b> <i>Albert L. Chason</i>			<b>22b. ADDRESS</b> <b>VA Hospital, K. C. Mo.</b>		
<b>22c. DATE SIGNED</b> <b>8/15/59</b>			(State)		
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>Burial</b>		<b>23b. DATE</b> <b>8-19-59</b>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Elmwood Cem. Highland K.C. Mo. Kans.</b>	
<b>24. FUNERAL DIRECTOR</b> <b>Gibson &amp; Son K.C.K.</b> ADDRESS		<b>25. DATE RECD. BY LOCAL REG.</b> <b>8-18-59</b>	<b>26. REGISTRAR'S SIGNATURE</b> <i>Neva Minshall</i>		

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed Phil C. Gibson

Licensed Embalmer No. 3135  
P.O. Address RCR

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to do so 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.