DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

OCT 18 1939

Registration District No. 399

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 1002

State File No. 331587

Registrar's No. 3685

1. PLACE OF DEATH:

(a) County Jackson 2

(b) City or town Kansas City, Missouri
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: 1321 Valentine Road
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____ (Specify whether
In this community _____ years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Kansas (b) County Wyandotte 2

(c) City or town Kansas City, Kansas.
(If outside city or town limits, write "RURAL")

(d) Street No. 4340 Pearl, K. C. K.
(If rural, give location)

(e) If foreign born, how long in U. S. A.? _____ years.

3. (a) PRINT FULL NAME Calvin D. Phillips 412

3. (b) If veteran, name war No

3. (c) Social Security No. 496,057,727

4. Sex Male

5. Color or race White

6. (a) Single, widowed, married, divorced married

6. (b) Name of husband or wife Libbie Phillips

6. (c) Age of husband or wife if alive 57 years

7. Birth date of deceased Aug. (Month) 1 (Day) 1883 (Year)

8. AGE: Years 56 | Months 1 | Days 18 | If less than one day _____ hr. _____ min.

9. Birthplace _____ (City, town, or county) Arkansas (State or foreign country)

10. Usual occupation Retired Watchman

11. Industry or business

FATHER
12. Name Phillips
13. Birthplace _____ (City, town, or county) Arkansas (State or foreign country)

MOTHER
14. Maiden name Don't Know
15. Birthplace _____ (City, town, or county) Don't Know (State or foreign country)

16. (a) Informant's own signature Mrs. Libbie Phillips
(b) Address 4340 Pearl, K. C. Kansas

17. (a) burial (Burial, cremation, or removal) (b) Date thereof 9-21-39 (Month) (Day) (Year)
(c) Place: burial or cremation Forest Hill

18. (a) Signature of funeral director Gates Funeral Home
(b) Address 1901 West 41st, K. C. K.

19. (a) Sept 20 1939 (Date received local registrar) (b) M. M. Crowe (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept. day 19th year 1939 hour 8 30 minute A M.

21. I hereby certify that I attended the deceased from [signature] 19__ to _____, 19__; that I last saw ___ alive on _____, 19__; and that death occurred on the date and hour stated above.

Immediate cause of death Hyperlesion Myocardium
Acute Pulmonary Edema

Due to _____

Due to _____

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____
Of autopsy Hyper Heart

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? _____ (Specify type of place)
While at work? _____ (e) Means of injury _____

23. Signature Russell W. Kerr (M. D. or other)
Address [signature] Date signed _____

(Licensed Embalmer's Statement on Reverse Side)

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

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

I X19511

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 wit the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.