

FILED NOV 12 1940
Registration District No. _____

Primary Registration District No. **1002**

Registrar's No. **4150**

1. PLACE OF DEATH:

(a) County Jackson
(b) City or town Jackson City
(c) Name of hospital or institution: Trinity Lutheran
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 11 Days
In this community _____
years, months or days

3. (a) PRINT FULL NAME Alice Phillips

8. (b) If veteran, name war. _____ 8. (c) Social Security No. _____

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced widow

6. (b) Name of husband or wife Charlie M. Phillips 6. (c) Age of husband or wife if alive 45 years

7. Birth date of deceased Feb 12 1875
(Month) (Day) (Year)

8. AGE: Years 65 Months 8 Days 16 If less than one day hr. _____ min. _____

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

10. Usual occupation Housewife

11. Industry or business _____

MOTHER FATHER { 12. Name William S Harris

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

14. Maiden name Hancy Ross

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

16. (a) Informant Clavel C Harris

(b) Address Banner St Young

17. (a) Burial (b) Date thereof 10-29-40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Harrisonville, Mo.

18. (a) Signature of funeral director RUNNENBURGER'S

(b) Address HARRISONVILLE, MO

19. (a) 10-29-40 (b) M. M. Crowe
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 28th
year 1940 hour 11 minute 30 P. M.

21. I hereby certify that I attended the deceased from 10-18-40
19 10-28 1940

that I last saw her alive on Oct 28 1940
and that death occurred on the date and hour stated above.

Immediate cause of death Coronary heart disease

Due to Toxic Thyroid

Due to _____

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

Major findings: Toxic Adenoma of Thyroid gland.

Of operations _____

Of autopsy No

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 Geo. J. Roberts (M. D. or other)
Address 618 Professional Bldg Date signed 10-29-40

Duration _____
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

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

Frank E. Remmenburg

Licensed Embalmer No. *2691*

P. O. Address *Harrisonville*

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, above space should be left blank.