

No. 2
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MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **41295**

50 JAN 8 1945
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Registration District No. _____

Primary Registration District No. _____

Registrar's No. **4688**

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

1. PLACE OF DEATH:

(a) County Jackson
(b) City or town Kansas City
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 314 Wabash
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community 55 Yrs
years, months or days

3. (a) PRINT FULL NAME Elmer Ellsworth Phipps

3. (b) If veteran, name war NO 3. (c) Social Security No. none

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Eva Mae Phipps 6. (c) Age of husband or wife if alive 69 years

7. Birth date of deceased July 21 1961
(Month) (Day) (Year)

8. AGE: Years 79 Months 3 Days 16 If less than one day _____ hr. _____ min.

9. Birthplace Mitchell Indiana
(City, town, or county) (State or foreign country)

10. Usual occupation Retired Grocer

11. Industry or business _____

MOTHER FATHER { 12. Name John A. Phipps

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

14. Maiden name Martha Hayes

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

16. (a) Informant Mrs Eva Mae Phipps

(b) Address 314 Wabash

17. (a) Burial (b) Date thereof Dec 10 1940
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Elmwood

18. (a) Signature of funeral director Mrs. C.L. Forster

(b) Address 918 Brooklyn

19. (a) 12-9-40 (b) M. M. Crowe
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson
(c) City or town Kansas City Mo.
(If outside city or town limits, write "RURAL")
(d) Street No. 314 Wabash
(If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec. 18 6 - 40
year 1940 hour _____ minute 1:45 P. M.

21. I hereby certify that I attended the deceased from _____ 19____
that I last saw _____ alive on _____ 19____
and that death occurred on the date and hour stated above.

Immediate cause of death Bullet wound, left head.
Due to _____
Due to 167

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

Major findings: _____
Of operations _____
Of autopsy _____

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) suicide

(b) Date of occurrence 12-6-40

(c) Where did injury occur? Home
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?
Home 5

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

23. Signature Russell (M. D. or other) _____
Address _____ Date signed _____

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 me

....., Registered Apprentice No.....

working under my personal supervision.

Signed.....

Licensed Embalmer No. 2590

P. O. Address R O M

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, fact should be so stated above.