

No. 2
M-5-43
5-17-39
I X38671

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **1676**
Registrar's No. **420**

FILED FEB 7 1946

Registration District No. **49** Primary Registration District No. **1002**

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:
1005 Penn. 1
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____ (Specify whether _____)

In this community 1 yr
years, months or days

3. (a) PRINT FULL NAME Charles Bert Phillips

3. (b) If veteran, name war no

3. (c) Social Security No. 214-05-7398

4. Sex MO

5. Color or race wh

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

6. (c) Age of husband or wife if alive 58 years

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

7. Birth date of deceased Aug 21 1887
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>58</u>	<u>5</u>	<u>3</u>	hr. _____ min. _____

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

10. Usual occupation Farmer, Laborer

11. Industry or business McKean & Robins, Dr. Co.

12. Name Ed. Phillips

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

14. Maiden name Hellen Williams

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

MOTHER FATHER

16. (a) Informant Harriet Phillips

(b) Address 1005 Penn

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 26-46
(Month) (Day) (Year)

(c) Place: burial or cremation Forest Hill

18. (a) Signature of funeral director M. C. R. Foster

(b) Address 718 Brooklyn

19. (a) 1-25-46 (Date received local registrar) (b) Estaline Holmes (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson

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

(d) Street No. 1005 Penn
(If rural, give location)

(e) Citizen of foreign country? _____ (Yes or No)

If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan. day 24
year 1946 hour 10 minute 30 P. M.

21. I hereby certify that I attended the deceased for 1 visit
24 Jan. 1946 to 24 Jan. 1946
that I last saw him alive on 24 Jan. 1946
and that death occurred on the date and hour stated above.

Immediate cause of death Coronary Thrombosis

Due to _____

Due to _____

Duration

7 hrs.

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations 94A

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) _____

(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 L. J. Givens (M. D. or other) M.D.

Address 1630 Professional Bldg. Date signed 24 Jan 46

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 with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.