

FILED MAY 18 1954

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **16103**  
**1968**

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **149** PRIMARY REG. DIST. NO. **1002** Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH a. COUNTY <b>Jackson</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>MINNESOTA</b> b. COUNTY <b>HENNEPIN</b>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>Kansas City</b>	c. LENGTH OF STAY (In this place) <b>7 days</b>	c. CITY OR TOWN <b>MINNEAPOLIS</b>	d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>Menorah Medical Center</b>		e. STREET ADDRESS (If rural, give location) <b>5524 YORK AVENUE 8228</b>	

3. NAME OF DECEASED (Type or Print) a. (First) <b>Andrew</b>	b. (Middle) <b>B.</b>	c. (Last) <b>Phipps</b>	4. DATE OF DEATH (Month) (Day) (Year) <b>April 29 54</b>
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5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>MARRIED</b>	8. DATE OF BIRTH <b>July 16, 1907</b>	9. AGE (In years last birthday) <b>46</b>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 6 HRS. Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>REGIONAL MANAGER</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>DESOTO MOTOR CORP.</b>	11. BIRTHPLACE (City and State or Foreign Country) <b>KANSAS CITY, MISSOURI</b>	12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>
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13a. FATHER'S NAME <b>William H. Phipps</b>	13b. MOTHER'S MAIDEN NAME <b>BERTHA A. READ</b>	14. NAME OF HUSBAND OR WIFE <b>ALICE PHIPPS</b>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No.</b>	16. SOCIAL SECURITY <b>495-05-4863</b>	17. INFORMANT'S SIGNATURE OR NAME <b>MRS. ALICE PHIPPS</b>	ADDRESS <b>5524 YORK AVENUE MINNEAPOLIS, MINNESOTA</b>
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  *This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH  <b>193X</b>
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Acute pulmonary edema + hypoxemia</b>		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <b>Acute atherosclerosis, both lower lobe, lungs</b> DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <b>Primary malignant tumor, brain, left temp. lobe.</b>			

19a. DATE OF OPERATION <b>4-28-54</b>	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (m.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from **4-22-1954** to **4-29-1954**, that I last saw the deceased alive on **4-29-1954**, and that death occurred at **5-12 P. m.**, from the causes and on the date stated above.

23a. SIGNATURE <b>F. A. Carmichael Jr. M.D.</b>	23b. ADDRESS <b>411 Nichols Rd.</b>	23c. DATE SIGNED <b>4-30-1954</b>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	24b. DATE <b>MAY 1, 1954</b>	24c. NAME OF CEMETERY OR CREMATORY <b>MEMORIAL PARK CEMETERY</b>	24d. LOCATION (City, town, or county) (State) <b>KANSAS CITY MISSOURI</b>
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DATE REC'D BY LOCAL REG. <b>5-1-54</b>	REGISTRAR'S SIGNATURE <b>Sheraldine Smith</b>	25. FUNERAL DIRECTOR'S SIGNATURE <b>J. H. Newcomer</b>	ADDRESS <b>1391 BRUSHWOOD DR. KANSAS CITY, MO.</b>
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

3305

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 ..... Student Embalmer No. .... working under my personal supervision..

Student.....  
Signature of Student Embalmer

Signed.....  
*Robert P. Kinnon*

Licensed Embalmer No. 48

P. O. Address.....  
A.C.

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.