

FILED JUN 5 1957

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

172886

STATE FILE NUMBER 2267

Registration District No. 149 Primary Registration District No. 1002

Registrar's No.

300  
1-57

1. PLACE OF DEATH a. COUNTY <b>JACKSON</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MISSOURI</b> b. COUNTY <b>JACKSON</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>KANSAS CITY</b>		c. CITY OR TOWN <b>KANSAS CITY</b>	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL <b>3620 EAST 59<sup>TH</sup> ST.</b>		d. STREET ADDRESS (If outside, give location) <b>3620 EAST 59<sup>TH</sup> STREET</b>	
Length of stay in lb <b>22 YEARS</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>ROBERT</b> Middle <b>KARL</b> Last <b>PHIPPS</b>			4. DATE OF DEATH Month <b>MAY</b> Day <b>14</b> Year <b>1957</b>
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>APRIL 29 1887</b>
9. AGE (In years last birthday) <b>70</b>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>SINCLAIR REFINING CO.</b>	11. BIRTHPLACE (City and state or country) <b>BENANGO COUNTY, PENNA.</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13a. FATHER'S NAME <b>ROBERT PHIPPS</b>		13b. MOTHER'S MAIDEN NAME <b>ARTHLINDA MCKEE</b>	14. NAME OF HUSBAND OR WIFE <b>CAROLINE PHIPPS</b>
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 NO. <b>487-03-3360</b>	17. INFORMANT <b>MRS. CAROLINE PHIPPS</b> Address <b>3620 EAST 59<sup>TH</sup> STREET KANSAS CITY, MISSOURI</b>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b>			INTERVAL BETWEEN ONSET AND DEATH <b>4201</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>In Hospital Aug 56 with Coronary Occlusion</b>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18)	
20c. TIME OF INJURY Hour _____ Month, Day, Year _____ a.m. _____ p.m. _____			
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION COUNTY STATE
21. I attended the deceased from _____ to _____ and last saw her alive on _____ Death occurred at _____ m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <b>Nugent A. Owens, Coroner</b>		22b. ADDRESS <b>1034 Pinalis Blv</b>	22c. DATE SIGNED <b>5-15-57</b>
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE <b>MAY 16 1957</b>	23c. NAME OF CEMETERY OR CREMATORY <b>MEMORIAL PARK CEMETERY</b>	23d. LOCATION (City, town, or county) (State) <b>KANSAS CITY MISSOURI</b>
24. FUNERAL DIRECTOR <b>DIV. NEW COMER'S SONS</b>		ADDRESS <b>1331 BRUSH CREEK KANSAS CITY, MO.</b>	25. DATE RECD. BY LOCAL REG. <b>5-16-57</b>
		26. REGISTRAR'S SIGNATURE <b>neva minshall</b>	

HUGH H. OWENS USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.



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 *Chester K Brown* .....

Licensed Embalmer No. *493* .....

P. O. Address *KE MO* .....

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.