MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Do not use this space.

8116

File No.

Registered No. 968

1. PLACE OF DEATH

County Jackson Registration District No. 399

Township Kaw Primary Registration District No.

City Kansas City (No. St. Lukes Hospital 1002 St. Ward)

2. FULL NAME Mary E. Keller

(a) Residence. No. 6408 East 35th St., Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)
Female	White	Married

5a. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Harry C. Keller

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Mar 7 1879

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ...hrs. or ...min.
	47	11	29	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work House Wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) Franklyn
(STATE OR COUNTRY) Ills

PARENTS

10. NAME OF FATHER Z.T.O'Brien

11. BIRTHPLACE OF FATHER (CITY OR TOWN)
(STATE OR COUNTRY) N.C.

12. MAIDEN NAME OF MOTHER Caroline Beevers

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)
(STATE OR COUNTRY) Don'T Know

14. INFORMANT Harry C. Keller
(Address) 6408 East 35th st

15. FILED 3/10 27 19 M. M. Crowe
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Mar 6 1927

17. I HEREBY CERTIFY, That I attended deceased from Feb 28, 1927, to March 6, 1927, that I last saw h. alive on March 5, 1927, and that death occurred, on the date stated above, at 3a m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Uterine fibroids
Shock
SHR

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (SECONDARY) Shock

(duration) yrs. mos. 1 ds.

18. WHERE WAS DISEASE CONTRACTED —

IF NOT AT PLACE OF DEATH?

DID AN OPERATION PRECEDE DEATH? yes DATE OF March 6th 1927

WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS? —

(Signed) H. A. Breyfogle, M.D.

3-7, 1927 (Address) Medical Arts Bldg

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Brooking Cemetery

DATE OF BURIAL Mar 8 1927

20. UNDERTAKER R.V. Lindsay & Son

ADDRESS City

SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County Jackson — Registration District No. 399 — File No.

Township — Primary Registration District No. 1002 — Registered No. 968

City K. City (No. ..... St. ..... Ward)

2. FULL NAME Mary E. Keller

(a) Residence. No. ..... St., ... Ward. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word)
F	W	M

5A. IF MARRIED, WIDOWED, OR DIVORCED
HUSBAND OF
(OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) .....
(STATE OR COUNTRY)

PARENTS

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (CITY OR TOWN) .....
(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) .....
(STATE OR COUNTRY)

14. INFORMANT .....
(Address)

15. FILED 3/7 1927 M. M. Crowe
Asst REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Mar 6 1927

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ....., 19..... that I last saw h..... alive on ....., 19....., and that death occurred, on the date stated above, at ..... m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Uterine Fibroids shock

Benign

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) Shock

..... (duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH? .....

DID AN OPERATION PRECEDE DEATH? ..... DATE OF .....

WAS THERE AN AUTOPSY? .....

WHAT TEST CONFIRMED DIAGNOSIS? .....

(Signed) ....., M. D

, 19 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURIAL 19
20. UNDERTAKER	ADDRESS

SUPPLEMENTARY

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