

STANDARD CERTIFICATE OF DEATH

Registration District No. 399

Primary Registration District No. 1002

Registrar's No. 1925

1. PLACE OF DEATH:

(a) County Jackson
(b) City or town Kansas City
(c) Name of hospital or institution: K.C. Tbc. Muni. Hosp. (If not in hospital or institution, write street, number or location)
(d) Length of stay: In hospital or institution 172 8 days (Specify whether years, months or days)
In this community _____

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson 48
(c) City or town Kansas City 3 (If outside city or town limits, write "RURAL") 6
(d) Street No. 6901 Cleveland (If rural, give location) 0
(e) If foreign born, how long in U. S. A.? _____ years.

3. (a) PRINT FULL NAME

Joseph Keclik

3. (b) If veteran, name war _____

3. (c) Social Security No. 61510-1214

4. Sex M (race) W

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

6. (b) Name of husband or wife _____

6. (c) Age of husband or wife if alive _____ years (Day) (Year)

7. Birth date of deceased April 11 1909 (Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	32	1	4	hr. min.

9. Birthplace: Okla. City, Okla. (City, town, or county) (State or foreign country)

10. Usual occupation: Home - janitor

11. Industry or business: Holy Name Catholic Church

12. Name: Joe V. Keclik

13. Birthplace: unknown - foreign Bohemia (City, town, or county) (State or foreign country)

14. Maiden name: Frances Ganser

15. Birthplace: unknown - foreign Bohemia (City, town, or county) (State or foreign country)

16. (a) Informant: Hosp. Records

(b) Address: K.C. Tbc Hosp, K.S., Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: _____ (Month) (Day) (Year)

(c) Place: burial or cremation: St. Josephs - Shawnee Kansas

18. (a) Signature of funeral director: J. J. Jones (b) Address: Kansas City, Kansas

19. (a) May 16 - 1941 (Date received local registrar) (b) M. M. Crowe (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 15 year 1941 hour 12 minute 20/A M.

21. I hereby certify that I attended the deceased from May 7 1940 to May 15 1941; that I last saw him alive on May 15 1941 and that death occurred on the date and hour stated above.

Immediate cause of death: Pul Tbc

Due to: 13 1/2

Due to: 12 1/2

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

Major findings: Of operations _____ Of autopsy _____

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? _____ (Specify type of place) (e) Means of injury _____

23. Signature: [Signature] (M. D. or other)

Address _____ Date signed 5-16-41

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

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.....

D Ross Blanford

Licensed Embalmer No.....

4015

P. O. Address.....

413 State Line

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.