

Health,
Welfare
Public
Service

FILED JUL 8 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

'57 021154

STATE FILE NUMBER

Registration District No. 149

Primary Registration District No. 1007

Registrar's No. 2850

1. PLACE OF DEATH a. COUNTY Jackson			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY Jackson		
b. CITY (If outside corporate limits, give TOWNSHIP only) Kansas City		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN Kansas City		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 4014 Clark Ave.		Length of stay in lb Life	d. STREET ADDRESS 4014 Clark Ave.		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Sally Middle Ann Last KEEN Keen			4. DATE OF DEATH Month June Day 16 Year 1957		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept. 30, 1955	9. AGE (In years last birthday) IF UNDER 1 YEAR: Months 2 Days 24 IF UNDER 24 HRS.: Hours 34 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Child		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) Kansas City, Mo.		12. CITIZEN OF WHAT COUNTRY? U. S.
13a. FATHER'S NAME Clavin Keen		13b. MOTHER'S MAIDEN NAME Miriam Mertz			14. NAME OF HUSBAND OR WIFE -----
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. -----	17. INFORMANT Address Clavin Keen 4014 Clark K.C. Mo.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Broncho-pneumonia				INTERVAL BETWEEN ONSET AND DEATH 2 days?	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) malnutrition	DUE TO (c) Brain atrophy - prob. Schilder's Disease		1 yr.	
				1 1/2 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH (not related to the terminal disease condition given in PART I (a))				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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 _____ a.m. _____ p.m.	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE 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 9-30-55 to 10-10-57 and last saw her alive on 3-5-57 Death occurred at 2 A.M. on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) Ernest L. Glasscock, M.D.			22b. ADDRESS Flaga June Bldg.		22c. DATE SIGNED 6-17-57
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE June 18, 1957	23c. NAME OF CEMETERY OR CREMATORY Calvary		23d. LOCATION (City, town, or county) Kansas City, Mo. (State)	
24. FUNERAL DIRECTOR Thomas E. Quirk 4316 Troost Ave.			25. DATE RECD. BY LOCAL REG. 6-18-57	26. REGISTRAR'S SIGNATURE neva munsall	

Ernest L. Glasscock
MEDICAL CERTIFICATION
All diseases in Part I must be causally related.

Jackson

Jackson

Kansas City

Kansas City

4014 Clark Ave.

4014 Clark Ave.

June 16, 1957

Keen

Ann

Sally

Sept. 30, 1955

Female White

Kansas City, Mo.

Child

William Keen

Clavin Keen

Clavin Keen 4014 Clark K.C. Mo.

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.

Signed *Thomas E. Quirk*

Student Signature of Student Embalmer

Licensed Embalmer No. 377 P. O. Address *Thomas E. Quirk 4316 Troost Ave.*

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.

Thomas E. Quirk 4316 Troost Ave.