Health, Welfare Public Service

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FILED JUL 12 1957

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

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STATE FILE NUMBER 2892

Registration District No. 149 Primary Registration District No. 1007 Registrar's No. 358

1. PLACE OF DEATH
a. COUNTY: Jackson
b. CITY OR TOWN: Kansas City — Inside Limits: Yes [X] No [ ]
c. FULL NAME OF HOSPITAL OR INSTITUTION: Gen'l Hosp. #1 — Length of stay in 1b: 10 yrs.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Missouri b. COUNTY: Jackson
c. CITY OR TOWN: Kansas City — Inside Limits: Yes [X] No [ ]
d. STREET ADDRESS (If outside, give location): 5107 E. 30 — Reside on Farm: Yes [ ] No [X]

3. NAME OF DECEASED (Type or print): First: Reese Middle: Young Last: Keown

4. DATE OF DEATH: Month 6 Day 19 Year 1957

5. SEX: Male **6. COLOR OR RACE**: White **7. MARRIED** [ ] **NEVER MARRIED** [ ] **WIDOWED** [X] **DIVORCED** [ ]

8. DATE OF BIRTH: 4-13-1898 **9. AGE** (In years last birthday): 59 — 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): Laborer **10b. KIND OF BUSINESS OR INDUSTRY**: farmer

11. BIRTHPLACE (City and state or country): Missouri **12. CITIZEN OF WHAT COUNTRY?**: U. S. A.

13a. FATHER'S NAME: Thomas Melton Keown **13b. MOTHER'S MAIDEN NAME**: Mary Ann Jones **14. NAME OF HUSBAND OR WIFE**: Fern Keown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: none **17. INFORMANT**: Ellen Shepard Address: Warsaw, Mo.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) — INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Pulmonary edema
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b): Pulmonary fibrosis & pneumonitis
DUE TO (c):
525X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X] 2

20a. ACCIDENT [ ] **SUICIDE** [ ] **HOMICIDE** [ ] **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. Month, Day, Year

20d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ] **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 June 19, 1957, to June 19, 1957 and last saw him alive on June 19, 1957. Death occurred at 10:40 P.m. on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): B. I. Burns, M.D. **22b. ADDRESS**: 24th & Cherry **22c. DATE SIGNED**: 6-19-57

23a. BURIAL, CREMATION, REMOVAL (Specify): Removal **23b. DATE**: 6-20-57 **23c. NAME OF CEMETERY OR CREMATORY**: Englewood Cem. **23d. LOCATION** (City, town, or county) (State): Warsaw Mo.

24. FUNERAL DIRECTOR ADDRESS: Reser Mortuary, Warsaw Mo. **25. DATE RECD. BY LOCAL REG.**: 6-21-57 **26. REGISTRAR'S SIGNATURE**: Nera Marshall

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

All diseases in Part I must be causally related.

B. I. Burns

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 John R. Sidn

Licensed Embalmer No. 453

P. O. Address Kansas 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.