

FILED JAN 29 1958

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

1531

STATE FILE NUMBER

Registration District No. 146 Primary Registration District No. 3026 Registrar's No. 34

|   |                               |  |  |
|---|-------------------------------|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Jackson</u>   |                               | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>Missouri</u> b. COUNTY <u>Jackson</u>               |  |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Independence</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>   |                               | c. CITY OR TOWN <u>Independence, Mo.</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>                               |  |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Independence Hosp</u> Length of stay in 1b   |                               | d. STREET ADDRESS (If outside, give location) <u>108 W. Kansas</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>    |  |
| 3. NAME OF DECEASED (Type or print) First <u>Oscar</u> Middle <u>none</u> Last <u>Kehler</u>  |                               |  | 4. DATE OF DEATH Month <u>Jan</u> Day <u>24</u> Year <u>1958</u>                               |
| 5. SEX <u>Male</u>  | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Feb 9, 1885</u>  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)   |                               | 10b. KIND OF BUSINESS OR INDUSTRY  | 9. AGE (In years last birthday) <u>72</u> IF UNDER 1 YEAR Months Days Hours Min.               |
| 11. BIRTHPLACE (City and state or country) <u>Jamesson, Mo.</u>   |                               | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>   |  |
| 13a. FATHER'S NAME <u>Franklin P. Kehler</u>  |                               | 13b. MOTHER'S MAIDEN NAME <u>Ida Frances Hopkins</u>   | 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) <u>Unknown</u>  |                               | 16. SOCIAL SECURITY NO. <u>493-18-1387</u>   | 17. INFORMANT Address <u>Hospital Records, Independence, Mo.</u>                               |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cerebral thrombosis &amp; hemorrhage.</u><br>DUE TO (b) <u>arterial hypertension</u><br>DUE TO (c) <u>Carcinoma, Metastatic, recurrent.</u><br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>332XH</u> |                               |  | 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 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 <u>Sep 28, 1955</u> to <u>Jan 24, 1958</u> and last saw him alive on <u>Jan 24, 1958</u><br>Death occurred at <u>10:45 A.M.</u> on the date stated above; and to the best of my knowledge, from the causes stated.   |                               |  |  |
| 22a. SIGNATURE (Name or title) <u>John Richard Trues M.D.</u>   |                               | 22b. ADDRESS <u>10901 Wimmer Rd.</u>   |  |
| 22c. DATE SIGNED <u>1-25-58</u>   |                               |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removed</u>  |                               | 23b. DATE <u>1-25-58</u>   |  |
| 23c. NAME OF CEMETERY OR CREMATORY  |                               | 23d. LOCATION (City, town, or county) (State) <u>Gallatin, Mo.</u>   |  |
| 24. FUNERAL DIRECTOR ADDRESS <u>Hope Maternity, Gallatin, Mo.</u>   |                               | 25. DATE RECD. BY LOCAL REG. <u>1-25-58</u>  |  |
|   |                               | 26. REGISTRAR'S SIGNATURE <u>James Ray</u>   |  |

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.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
 MEDICAL CERTIFICATION

1090 / minutes  
- 2002 5000

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. Sidmo* .....  
Licensed Embalmer No. *4531* .....  
P. O. Address *Kansas City* .....

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.