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THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

59-005660
STATE FILE NUMBER

FILED FEB 19 1959 Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 635

1. PLACE OF DEATH
a. COUNTY Jackson
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kansas City — Inside Limits Yes [X] No [ ]
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 4601 Liberty — Length of stay in 1b: 30 Years

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 4601 Liberty (If outside, give location) — Reside on Farm Yes [ ] No [ ]

3. NAME OF DECEASED (Type or print): First ROBERT Middle BLAND Last KEAN

4. DATE OF DEATH Month Feb. Day 1 Year 1959

5. SEX Male

6. COLOR OR RACE White

7. MARRIED [X] **NEVER MARRIED** [ ] **WIDOWED** [ ] **DIVORCED** [ ]

8. DATE OF BIRTH Oct. 20, 1880

9. AGE (In years last birthday) 78 — 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) Salesman

10b. KIND OF BUSINESS OR INDUSTRY Waldo Furniture

11. BIRTHPLACE (City and state or country) Baltimore, Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13a. FATHER'S NAME John L. Kean

13b. MOTHER'S MAIDEN NAME Patti Bland

14. NAME OF HUSBAND OR WIFE Ada Louise Kean

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. 509-05-0069

17. INFORMANT Mrs. Ada Louise Kean, 4601 Liberty, K.C.Mo

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) ACUTE PYELONEPHRITIS — INTERVAL BETWEEN ONSET AND DEATH: 1 wk.
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b) CARCINOMA OF PROSTATE — 7 years.
DUE TO (c) 1978
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]

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 10-15-1957, to JAN 31, 1959 and last saw him alive on JAN 31, 1959
Death occurred at 9:30 A m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE Milton B. Ozar (Degree or title) MD

22b. ADDRESS 701 E. 63rd KCMo.

22c. DATE SIGNED 2-2-59

23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL

23b. DATE Feb. 3-1959

23c. NAME OF CEMETERY ~~OR CREMATORY~~ MT. MORIAH CEMETERY

23d. LOCATION (City, town, or county) KANSAS CITY (State) Mo.

24. FUNERAL DIRECTOR D.W. Newcomers Sons — ADDRESS 7331 Brush Creek Blvd. KANSAS City, Mo.

25. DATE RECD. BY LOCAL REG. 2-3-59

26. REGISTRAR'S SIGNATURE Neva Marshall

(Licensed Embalmer's Statement on Reverse Side)

All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

Milton B. Ozar

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 Robert Ray

Licensed Embalmer No. 4182

P. O. Address K. C., Mo.

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.