

Health,
Fare,
Public
Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-009594

FILED MAR 26 1959

Registration District No. 149 Primary Registration District No. 1002 STATE FILE NUMBER 1280 Registrar's No. 1280

00
57

1. PLACE OF DEATH a. COUNTY Jackson		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Jackson	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kansas City		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN Kansas City 500 Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION Menorah Medical Center		Length of stay in 1b 36 years	d. STREET ADDRESS (If outside, give location) 3513 Gillham Rd. Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Patric Middle Ruth Last O'Keefe			4. DATE OF DEATH Month 3 Day 9 Year 59
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> 3 DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 7-17-1897
9. AGE (In years last birthday) 61		IF FUNDER 1 YEAR Months 3 Days 9	IF UNDER 24 HRS Hours 59 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Director of Health & Physical Ed.		10b. KIND OF BUSINESS OR INDUSTRY Leavenworth, Kansas	11. BIRTHPLACE (City and state or country) U. S. A.
12. CITIZEN OF WHAT COUNTRY? U. S. A.		13a. FATHER'S NAME Eugene O'Keefe	13b. MOTHER'S MAIDEN NAME Olive Helsby
14. NAME OF HUSBAND OR WIFE Earl Kirchner		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	16. SOCIAL SECURITY NO. 478-32-7958
17. INFORMANT Olive Roberts, 3513 Gillham Rd. K.C.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Ch. Myeloid Leukemia			INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____			
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 <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 _____ a.m. _____ p.m. _____			
20d. INJURY OCCURRED WHILE AT <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 Kansas City		COUNTY Missouri STATE	
21. I attended the deceased from Jan 24-59 to March 9-59 and last saw her alive on March 9-59 Death occurred at 10:15 a.m. on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE Jack B. Brams MD (Degree or title)		22b. ADDRESS 757 E 62	
22c. DATE SIGNED 3-9-59			
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		23b. DATE Mch. 11, '59	
23c. NAME OF CEMETERY OR CREMATORY D.W. Newcomer's Sons		23d. LOCATION (City, town, or county) (State) Kansas City Missouri	
24. FUNERAL DIRECTOR D.W. Newcomer's Sons, K.C., Missouri		DATE RECD. BY LOCAL REG. 3-10-59	
26. REGISTRAR'S SIGNATURE Neve Marshall			

MEDICAL CERTIFICATION
USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
All diseases in Part I must be causally related.
Jack B. Brams

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 *Edward M. Star*

Licensed Embalmer No. *445*
P. O. Address *K. C. 101*

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.