RI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

FILED VS OCT 31 1960 149

5141 ~~5151~~ 60-038430 STATE FILE NUMBER

Registration District No. _____ Primary Registration District No. 1002 Registrar's No. _____

DED

1. PLACE OF DEATH
a. COUNTY Jackson
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kansas city Mo — Length of stay in 1b: 1 Month
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St Lukes Hospital — Inside Limits Yes ☒ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Kansas b. COUNTY Johnson
c. CITY OR TOWN Overland Park — Inside Limits Yes ☒ No ☐
d. STREET ADDRESS (If outside, give location) 8502 Grandview — Reside on Farm Yes ☐ No ☒

3. NAME OF DECEASED (Type or print) First: Mrs Middle: Sarah Last: Florence Keller
4. DATE OF DEATH Month 10 Day 12 Year 1960
5. SEX Female
6. COLOR OR RACE White
7. Married ☐ Never Married ☐ Widowed ☒ Divorced ☐
8. DATE OF BIRTH 7-21-1890
9. AGE (last birthday) 70
IF UNDER 1 YEAR: Months ___ Days ___ IF UNDER 24 HR: Hours ___ Min. ___
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife
10b. KIND OF BUSINESS OR INDUSTRY at Home
11. BIRTHPLACE (City and state or country) Chillothe, Missouri
12. CITIZEN OF WHAT COUNTRY U.S.A.
13a. FATHER'S NAME George Bevelle
13b. MOTHER'S MAIDEN NAME Agnes Tibergan
14. NAME OF HUSBAND OR WIFE Otto Keller
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No
(If yes, give war or dates of service) No
16. SOCIAL SECURITY NO. —
17. INFORMANT Mary Cutting Address 11306 W 67th Ter Shawnee Kansas

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) Carcinoma of Pancreas — INTERVAL BETWEEN ONSET AND DEATH 6 Mo
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)
PART III. If deceased was female was there a pregnancy in last 90 days. ☐ Yes ☐ No ☐ Unknown

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒
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 April 1960 to Oct 12/60 and last saw her ~~him~~ alive on Oct 12/60
Death occurred at 9:04 Am on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE A. L. Spafford (Degree or title) M.D.
22b. ADDRESS 315 Nichols Rd K.C. Mo
22c. DATE SIGNED 10/12/60

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial
23b. DATE 10-14-60
23c. NAME OF CEMETERY OR CREMATORY Green Lawn
23d. LOCATION (City, town, or county) Kansas City (State) Mo

24. FUNERAL DIRECTOR Wornall Funeral Home Inc ADDRESS
25. DATE RECD. BY LOCAL REG. 10-13-60
26. REGISTRAR'S SIGNATURE H. L. Dwyer

(Licensed Embalmer's Statement on Reverse Side)

BY AFFIDAVIT OF A. L. Spafford

DOCUMENT

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by

or by _____, Student Embalmer No._____

working under my personal supervision.

Student_____ Signed Russell N. Fra

Signature of Student Embalmer

Licensed Embalmer No. 425

P. O. Address K.C.,

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to co 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.