

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

60-046160

FILED VS DEC 19 1960

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 5923 STATE FILE NUMBER

DED

1. PLACE OF DEATH a. COUNTY <u>Jackson</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>Jackson</u>					
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Kansas City</u>		Length of stay in lb <u>50 yrs</u>		c. CITY OR TOWN <u>Kansas City</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>De Lora Rest Home</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>816 Fremont</u>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>Oberlin</u> Last <u>Kellar</u>				4. DATE OF DEATH Month <u>11</u> Day <u>24</u> Year <u>1960</u>					
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <u>2-22-1883</u>	9. AGE (last birthday) <u>77</u>	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) <u>House wife</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>at home</u>		11. BIRTHPLACE (City and state or country) <u>Quebec, Canada</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A</u>		
13a. FATHER'S NAME <u>Paul Bourquet</u>			13b. MOTHER'S MAIDEN NAME <u>Mary Le Roi</u>			14. NAME OF HUSBAND OR WIFE <u>Newton W. Kellar</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>			16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>Bella Mae Engleman Barnett</u>			Address <u>729 K.C.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage</u>							INTERVAL BETWEEN ONSET AND DEATH <u>48 hours</u>		
DUE TO (b) <u>cerebral arterio sclerosis</u>							<u>years</u>		
DUE TO (c) _____									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Left hemiplegia</u>					PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown				
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. Month, Day, Year _____		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>APR 5, 1960</u> to <u>NOV 24, 1960</u> and last saw her alive on <u>NOV 22, 1960</u> Death occurred at <u>8:00</u> a.m. on the date stated above, and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE (Degree or title) <u>M. A. Cliné M. D.</u>			22b. ADDRESS <u>4126 St. John KC 23, Mo.</u>			22c. DATE SIGNED <u>11-25-60</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>11-29-1960</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Washington Cem.</u>			23d. LOCATION (City, town, or county) <u>15. C. MO</u>		23e. STATE <u>MO</u>		
24. FUNERAL DIRECTOR <u>C. H. Blackman & Son R.C. Mo</u>				25. DATE RECD. BY LOCAL REG. <u>11-25-60</u>		26. REGISTRAR'S SIGNATURE <u>H-L-Dwyer</u>			

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF
Cliné

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 _____
Signature of Student Embalmer

Signed _____

Licensed Embalmer No. _____

P. O. Address _____

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.