SSOURI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

-61-021580
STATE FILE NUMBER

AMENDED

Registration District No. 154 Primary Registration District No. 5575 Registrar's No. 16

FILED JUN 28 1961

1. PLACE OF DEATH
a. COUNTY Jackson
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Grandview — Length of stay in 1b: 34 yr
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Grandview Restorium — Inside Limits: Yes ☑ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Mo b. COUNTY Jackson
c. CITY OR TOWN Kansas City — Inside Limits: Yes ☑ No ☐
d. STREET ADDRESS (If outside, give location) 3819 E. 53 St. — Reside on Farm: Yes ☐ No ☑

3. NAME OF DECEASED (Type or print) First: MARY Middle: ANNA Last: KEITH
4. DATE OF DEATH Month: 6 Day: 19 Year: 1961
5. SEX: Female
6. COLOR OR RACE: White
7. Married ☐ Never Married ☐ Widowed ☑ Divorced ☐
8. DATE OF BIRTH: 7/28/1880
9. AGE (last birthday): 80
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: Home
11. BIRTHPLACE (City and state or country): Unknown
12. CITIZEN OF WHAT COUNTRY: U.S.A.
13a. FATHER'S NAME: Unknown
13b. MOTHER'S MAIDEN NAME: Unknown
14. NAME OF HUSBAND OR WIFE: Sylvester F. Keith
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.
17. INFORMANT: Mrs. R. D. Messerschmidt Address: (Grandview)

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) Hypostatic Pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 3 days
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b) debility & dehydration — 3 wks
DUE TO (c) cerebral arteriosclerosis — 10 years
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 6/1/59, to 6/18/61 and last saw her/him alive on 6/16/61
Death occurred at 10:45 p.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): Boyd L. Harris M.D.
22b. ADDRESS: Grandview Mo
22c. DATE SIGNED: 6/20/61

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE: 6/21/1961
23c. NAME OF CEMETERY OR CREMATORY: Forest Hill Cem.
23d. LOCATION (City, town, or county) (State): Kansas City, Mo.
24. FUNERAL DIRECTOR ADDRESS: C. H. Blackmon & Son K.C., Mo
25. DATE RECD. BY LOCAL REG.: 6/20/61
26. REGISTRAR'S SIGNATURE: Sherlund E. Doddard

(Licensed Embalmer's Statement on Reverse Side)

ITEM NO. | SHOULD READ | INSTEAD OF | DATE AMENDED
BY AFFIDAVIT OF DOCUMENT

1991 Br. Rd

JUN 28 1961

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 W. C. Rennie

Licensed Embalmer No. 4829

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.